# N.J.A.C. TITLE 8

# Chapter 42A

# Manual of Standards for Licensure of Residential Substance Abuse Treatment Facilities

**Authority**

**N.J.S.A. 26:2H-1 et seq.**

**Effective Date:** **November 15, 1999**

**Expiration Date:** **November 15, 2004**

**New Jersey Department of Health and Senior Services**
**Division of Addiction Services**
**P.O. Box 362**
**Trenton, New Jersey 08625-0362**
**Telephone: (609) 292-5760**

**To make a complaint about a New Jersey licensed facility,**
**call 1-800-792-9770 (Toll-Free Hotline)**

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# STANDARDS FOR LICENSURE OF

# RESIDENTIAL SUBSTANCE ABUSE TREATMENT FACILITIES

## SUBCHAPTER 1. DEFINITIONS AND QUALIFICATIONS

### 8:42A-1.1 Scope and applicability

(a) This chapter applies to all residential health care facilities which provide substance abuse treatment, including, but not limited to, halfway houses, extended care facilities, therapeutic communities, short-term residential treatment programs and non-hospital based (medical) detoxification, or any other similar such organization.

(b) This chapter also applies to hospitals licensed pursuant to N.J.A.C. 8:43G which offer hospital-based medical detoxification services in a designated detoxification unit or facility or provide any of the modalities of residential substance abuse treatment listed in (a) above. This chapter, while not requiring a separate license for hospital-based substance abuse treatment programs, sets out standards with which hospitals providing services covered by this chapter must comply.

(c) Facilities currently licensed as Alcoholism Treatment Facilities or Drug Treatment Facilities shall comply with this chapter and shall apply for licensure as a residential substance abuse treatment facility upon expiration of existing licenses, in accordance with (a) or (b) above.

### 8:42A-1.2 Purpose

The purpose of this chapter is to establish minimum requirements to which a residential substance abuse treatment program must adhere in order to be licensed to operate in New Jersey.

### 8:42A-1.3 Definitions

The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise:

**"Admitted"** means accepted for treatment at a residential substance abuse treatment facility.

**"ASAM"** means the American Society of Addiction Medicine, 4601 North Park Ave., Upper Arcade, Suite 101, Chevy Chase, MD 20815.

**"ASAM Patient Placement Criteria"** means the criteria developed by the American Society of Addiction Medicine, contained in "Patient Placement Criteria for the Treatment of Substance Related Disorder," 2d Edition (1996) (ASAM-PPC2) incorporated herein by reference.

**"ASI"** means the Addiction Severity Index designed to provide important information about aspects of a patient's life which may contribute to his or her substance abuse syndrome, as developed by the Treatment Research Institute, One Commerce Square, Suite 1120, 2005 Market Street, Philadelphia, PA 19103.

**"Available"** means, with respect to individuals employed by, or under contract with, a residential substance abuse treatment facility, capable of being reached and able to be present in the facility within thirty minutes.

**"BOCA"** means the model code of the Building Officials and Code Administrators International Inc., which can be obtained at 4051 W. Flossmoor Road, Country Club Hills, IL 60477-5795.

**"Chemical dependence"** means chronic or habitual use of alcohol, tobacco, any kind of controlled substance, narcotic drug, or other prescription or non-prescription drug, including, but not limited to, opium, heroin, morphine, cocaine, or any derivative of such drugs, or any barbiturate, central nervous system stimulant, tranquilizer or other depressant, hallucinogenic drug, or any other drug subject to regulation.

**"Clear floor area"** means room space exclusive of toilet rooms, fixed closets, fixed wardrobes, alcoves or vestibules.

**"Clinical note"** means a written, signed, and dated notation made by a credentialed professional who renders a service to the patient.

**"Clinical record"** means all records in the facility which pertain to the patient's care.

**"Commissioner"** means the Commissioner of the New Jersey Department of Health and Senior Services.

**"Communicable disease"** means an illness due to a specific infectious agent or its toxic products, which occurs through transmission of that agent or its products from a reservoir to a susceptible host.

**"Contamination"** means the presence of an infectious or toxic agent in the air, on a body surface, or on/in clothes, bedding, instruments or dressings, or other inanimate articles or substances, including water, milk, and food.

**"Controlled dangerous substances" or "controlled substances"** means drugs subject to the Federal Controlled Dangerous Substances Act of 1970 (Title 11, Public Law 91-513) and the New Jersey Controlled Dangerous Substances Act of 1970, N.J.S.A. 24:21-1 et seq.

**"Daily census "** means the number of patients residing in the facility on any given day.

**"Department"** means the New Jersey Department of Health and Senior Services.

**"Designated person"** means the person designated by the patient to be notified: if the patient sustains an injury requiring medical care; if an accident or incident occurs; if there is deterioration in the patient's physical or mental condition; if the patient is transferred to another facility, or if the patient is discharged or expires.

**"Detoxification (medical)"** means the provision of short-term care prescribed by a physician and conducted under medical supervision, for the removal of the physiological affect of a drug or substance from an addicted individual according to established medical protocol.

**"Didactic session"** means a structured treatment intervention designed to instruct or teach patients about topics related to their substance abuse treatment.

**"Discharge plan"** means a written plan initiated at the time of the patient's admission, and added to during the course of the patient's treatment, which addresses the needs of the patient after discharge.

**"Drug"** means any article recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States or official National Formulary, or any supplement to those sources, including, but not limited to, a controlled substance, a prescription legend drug, an over-the-counter preparation, a vitamin or food supplement, or any compounded combination of any of the above or transdermal patch or strip, intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease or medical condition in humans or intended to affect the structure or function of the human body.

**"Extended care facility"** means a residential substance abuse treatment facility in which treatment primarily is designed to help patients overcome denial of addiction, enhance treatment acceptance and motivation, prevent relapse, promote reintegration into the community, and generally approximate the ASAM Patient Placement Criteria, Level III.3 (medium intensity) treatment modality.

**"Facility"** means a residential substance abuse treatment facility licensed to provide substance abuse treatment services by the Department. These facilities include halfway house, extended care programs, therapeutic communities programs, short-term residential programs and any similar program in which care is provided through a structured recovery environment involving professional clinical services and/or specific services for detoxification for hospital-based facilities.

**"Family"** means immediate kindred, legal guardian, legally authorized representative, executor, or an individual granted a power of attorney. The term may also be expanded to include those persons having a commitment and/or personal significance to the patient, provided that the primary legal rights of the immediate next of kin, legal guardian, legally authorized representative, executor, or an individual granted a power of attorney, have been satisfied.

**"Floor stock"** means medications from a pharmacist in a labeled container in limited quantities that are not necessarily prescribed for one or more specific individuals.

**"Governing authority"** means the organization, person, or persons designated to assume legal responsibility for the management, operation, and financial viability of the facility.

**"Halfway house"** means a residential substance abuse treatment facility in which treatment primarily is designed to assist patients in adjusting to regular patterns of living, engaging in occupational training, obtaining gainful employment and independent self-monitoring and otherwise generally approximates the ASAM Patient Placement Criteria, Level III.1 (low intensity) treatment modality.

**"Handicapped"** means disabled as defined in the Federal Americans with Disabilities Act, 1990, 42 U.S.C.A. 12101 et seq.

**"Incapacitated"** means that a person, as a result of the use of alcohol or other drugs, is unconscious or has his or her judgement so impaired that he or she is incapable of realizing and making a rational decision with respect to his or her need for treatment even though he or she is in need of substantial medical attention.

**“Intoxicated"** means that a person’s mental or physical functioning is substantially impaired as a result of the use of alcoholic beverages or other mood-altering chemicals.

**"Juvenile"** means a person under the age of 18 years.

**"Juvenile residential substance abuse treatment facility"** means a free standing residential facility or a distinct part of a health care facility where care is provided to two or more juvenile patients for the treatment and prevention of substance dependence, under supervision for more than 24 consecutive hours.

**"Legally authorized representative"** means a patient's spouse, immediate next of kin, legal guardian, executor, or an individual granted a power of attorney.

**"Long-term residential substance abuse treatment program or long-term residential facility"** means a residential substance abuse facility including therapeutic communities in which treatment is primarily designed to foster personal growth and social skills development, with intervention focused on reintegraing the patient into the greater community, and where education and vocational development are emphasized. (See the ASAM Patient Placement Criteria, Level III.5 (high intensity, clinically-managed) treatment modality.)

**"Medical liaison"** means a designated staff member in a residential substance abuse treatment facility responsible for ensuring that all medical information is entered into the patient's clinical records.

**"Medication"** means a substance so defined by the New Jersey State Board of Pharmacy rules, as set forth in N.J.A.C. 13:39.

**"Medication dispensing"** means a procedure entailing the interpretation of the original or direct copy of the prescriber’s order for a medication or a biological and, pursuant to that order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological to a patient or a service unit of the facility, in conformance with the rules of the New Jersey Board of Pharmacy at N.J.A.C. 13:39.

**"Multidisciplinary team"** means those persons, representing different professions, disciplines, and service areas, who work together to provide care to the patient.

**"Non-hospital based (medical) detoxification"** means a residential substance abuse treatment facility designed primarily to provide short-term care prescribed by a physician and conducted under medical supervision to treat a patient's physical symptoms caused by addictions, according to medical protocols appropriate to each type of addiction, and generally approximates ASAM Patient Placement Criteria, Level III.7D (medically monitored intensive in-patient detoxification) treatment modality.

**"Nosocomial infection"** means an infection acquired by a patient while in the residential substance abuse treatment facility.

**"Patient treatment plan"** means a written plan, coordinating the projected series and sequence of treatment procedures and services based on an individualized evaluation of what is needed to restore or improve the health and function of the patient.

**"Per diem rate"** means the daily charge to the patient or other funding source for services rendered by the facility.

**"Practitioner"** means a person licensed to practice medicine or surgery in accordance with N.J.S.A. 45:9-1 et seq. and N.J.A.C. 13:35 or a medical resident or intern, or a podiatrist licensed pursuant to N.J.S.A. 45:5-1 et seq. and N.J.A.C. 13:35.

**"Progress note"** means a written, signed, and dated notation by a member of the multidisciplinary team summarizing facts about care and the patient's response during a given period of time.

**"Residential substance abuse treatment facility" or "facility"** means a facility, or a distinct part of a facility which provides health care for the treatment of substance abuse, for 24 or more consecutive hours to two or more patients who are not related to the governing authority or its members by marriage, blood or adoption. The term "residential substance abuse treatment facility" includes facilities which provide residential substance abuse treatment services to juveniles, women and children and adult males and or females. These facilities include halfway houses, extended care programs, long-term residential programs including therapeutic communities and includes, short-term residential programs and any similar program in which care is provided through a structured recovery environment involving professional clinical services and/or specific services for detoxification for hospital-based facilities.

**"Restraint"** means a physical device or drug used to limit, restrict, or control patient movements.

**"Self-administration"** means a procedure in which any medication is taken orally, injected, inserted, or topically or otherwise administered by a patient to himself or herself

**"Short-term residential substance abuse treatment program or "short-term residential facility"** means a substance abuse treatment program located in a residential substance abuse treatment facility in which treatment is designed primarily to address specific addiction and living skills problems through a prescribed 24-hour per day activity regimen on a short-term basis. (See the ASAM Patient Placement Criteria, Level III.7 (medically monitored intensive in-patient treatment) treatment modality.)

**"Signature"** means at least the first initial and full surname and title, if applicable, (for example, R.N., L.P.N., D.D.S., M.D.) of a person, legibly written with his or her own hand.

**"Substance abuse"** means a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. There may be repeated failure to fulfill major role obligations, repeated use in situations in which it is physically hazardous, multiple legal problems, and recurrent social and interpersonal problems. For the purpose of this chapter, substance abuse also means other substance related disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, 1994, as amended and supplemented, published by the American Psychiatric Association, 1400 K. St. N.W., Washington, DC 20005, incorporated herein by reference.

**"Supervision (direct)"** means supervision provided on the premises within view.

**"Therapeutic community"** means a residential substance abuse facility in which treatment is primarily designed to foster personal growth and social skills development, with intervention focused on reintegrating the patient into the greater community, and where education and vocational development are emphasized. (See the ASAM Patient Placement Criteria, Level III.5 (high intensity, clinically-managed) treatment modality.)

**"Therapeutic diet"** means a diet prescribed by a physician, which may include modifications in nutrient content, caloric value, consistency, methods of food preparation, content of specific foods, or a combination of these modifications.

**"Tobacco products"** means any manufactured nicotine delivery article that contains tobacco or reconstituted tobacco.

**"Unit dose distribution system"** means a system in which medications are delivered to the patient areas in single unit packaging.

**"Volunteer"** means a person (non-patient) who works at the facility on a non-reimbursed basis.

**8:42A-1.4 Qualifications of the medical director, director of nursing, psychiatrists and psychologists**

(a) Residential substance abuse treatment facilities shall employ practitioners and other providers to provide the scope of services set forth in this chapter who are licensed in accordance with the laws of this State to perform such services.

(b) In addition to (a) above, facilities required under N.J.A.C. 8:42A-7 to hire a medical director, shall engage as director a physician who is certified by the American Society of Addiction Medicine (ASAM) by November 15, 2002; and

1. Has successfully completed a residency program in a medical specialty related to services provided by the facility accredited by the Accreditation Council for Graduate Medical education or approved by the American Osteopathic Association; or

2. Is a diplomat of one of the certifying boards approved by the American Board of Medical Specialties or one of the certifying boards of the American Osteopathic Association on a medical specialty related to services provided by the residential substance abuse facility.

(c) Residential treatment facilities which are not required to have a medical director but which choose to do so shall also abide by (b) above.

(d) In addition to (a) above, if the facility is required to hire, or elects to hire, a nursing director pursuant to N.J.A.C. 8:42, the facility shall engage as nursing director a registered professional nurse who has at least one year of full-time experience, or the full-time equivalent, in nursing supervision or nursing administration and one year full-time experience or the full-time equivalent with the management of addictions in a licensed substance abuse treatment facility.

(e) In addition to (a) above, if the facility is required to hire, or elects to hire, a psychiatrist, the facility shall engage psychiatrists who:

1. Are certified or eligible for certification by the American Board of Psychiatry and Neurology, Inc., or the American Osteopathic Board of Neurology and Psychiatry; or

2. Have been granted privileges to provide services equal to or greater than those provided by a Board-certified or Board-eligible physician.

(f) Notwithstanding (a) above, the facility may engage psychologists certified by the New Jersey Board of Education not otherwise licensed by the New Jersey State Board of Psychological Examiners.

**8:42A-1.5 Qualifications of the administrator of the facility**

(a) The facility shall engage an administrator who shall have:

1. A master's degree and two years of full-time, or full-time equivalent, administrative or supervisory experience in a substance abuse treatment facility; or

2. A baccalaureate degree and four years of full-time, or full-time equivalent, administrative or supervisory experience or training in a substance abuse treatment facility.

(b) Individuals who do not meet the qualifications in (a) above but hold the position of administrator on November 15, 1999 will be exempt from the requirements in (a) above only for as long as that individual holds that specific position with their current agency. This exemption is not transferable to any other position or individual.

**8:42A-1.6 Qualifications for dieticians**

The facility shall engage dieticians registered by the Commission on Dietetic Registration (Office on Dietetic Credentialing, 216 West Jackson Boulevard - 7th Floor, Chicago, Illinois 60606-6995).

**8:42A-1.7 Qualifications of the director of substance abuse counseling services**

(a) The facility shall engage as the director of substance abuse counseling an individual certified as a Certified Clinical Supervisor by the Addiction Professionals Certification Board of New Jersey, 5A Aver Court, East Brunswick, NJ 08816, by November 15, 2002, who shall:

1. Have a master's degree in human services, the mental health or social work fields, with at least five years of experience in addiction services, with two of those years in a supervisory capacity, and be a Licensed Clinical Alcohol and Drug Counselor or Certified Alcohol and Drug Abuse Counselor; or

2. Have a doctoral degree in human services, mental health, social work or medicine, with at least two years of supervisory experience and at least one of the following certifications:

   i. Licensed or Certified Alcohol and Drug Abuse Counselor (LCADC or CADC);

   ii. Certified Clinical Supervisor (CCS);

   iii. American Society of Addiction Medicine (ASAM) board certification;

   iv. American Psychological Association, College of Professional Psychology, Certification of Proficiency in the Treatment of Alcohol and other Psychoactive Substance Use Disorders; or

   v. American Board of Psychiatry and Neurology, Certificate in Added Qualifications in Addiction Psychiatry.

(b) Individuals who do not meet the qualifications in (a) above, but hold the position of director of substance abuse counseling on November 15, 1999, will be required to meet the requirements for this position set forth in (a) above by November 15, 2002.

**8:42A-1.8 Qualifications of the food services supervisor**

(a) The facility shall engage food service supervisors who, if not dieticians, are:

1. Graduates of a dietetic technician or dietetic assistant training program approved by the American Dietetic Association, 216 West Jackson Blvd., 7th Floor, Chicago, Illinois, 60606-6995; or

2. Graduates of a course providing 90 or more hours of classroom instruction in food service supervision approved by the New Jersey Department of Education, and have one year of full-time experience, or the full-time equivalent, as a food service supervisor in a health care facility in consultation with a dietician; or

3. Trained and experienced in food service supervision and management through military service programs equivalent to (a) 1 or 2 above.

**8:42A-1.9 Qualifications of the substance abuse counseling staff**

(a) Every facility shall engage a substance abuse counseling staff such that 75 percent of the staff are certified as Licensed Clinical Alcohol and Drug Counselors (LCADC) or Certified Alcohol and Drug Counselors (CADC) by November 15, 2002, and at all times thereafter.

1. Each substance abuse counselor shall be a Licensed Clinical Alcohol or Drug Counselor or Certified Alcohol and Drug Abuse Counselor.

2. Substance abuse counselors in training who are not LCADC or CADC shall:

i. Be enrolled in a course of study leading to certification as a CADC or LCADC;

ii. Receive in-service training;

iii. Be trained and evaluated before being assigned counseling responsibilities;

iv. Make satisfactory progress toward certification, with such progress reviewed and documented by the facility at least semiannually;

v. Become credentialed within three years of the date of hire by the facility or by November 15, 2002, whichever date is later;

vi. Represent not more than 25 percent of total counseling staff within three years by November 15, 2002; and

vii. Be counted towards the patient to counselor ratio only when the counselor in training has completed his or her in-service training and been evaluated by the Director of Substance Abuse Counseling prior to being assigned counseling responsibilities.

## SUBCHAPTER 2. LICENSURE PROCEDURES

### 8:42A-2.1 General process

(a) No facility shall be licensed to operate a residential substance abuse treatment facility prior to March 1, 2000 (or such earlier date as may be established by the Commissioner by regulation or other notice through the New Jersey Register in accordance with N.J.S.A. 26:2H-7c) until that facility has received a certificate of need approval letter from the Commissioner.

1. A facility seeking to obtain a certificate of need approval letter to institute, construct, expand or become licensed to operate a residential substance abuse treatment facility shall comply with the requirements of N.J.A.C. 8:33, Certificate of Need: Application and Review, generally, and N.J.A.C. 8:33-5, Expedited Review, specifically.

2. A facility that fails to comply with the conditions, if any, set forth in its certificate of need approval letter shall be subject to penalties and fines available under law, and shall not be eligible for a license, or may be subject to revocation of licensure as a residential substance abuse treatment facility or other appropriate penalty, if a license has been issued.

3. Pursuant to N.J.A.C. 8:43E, licensure applicants may seek pre-licensure suitability review in accordance with the provisions set forth therein.

(b) No facility shall operate a residential substance abuse treatment facility until issued a license to do so by the Department. Applications for licensure may be obtained as follows:

1. Following receipt of a certificate of need approval letter, a facility shall obtain application forms from and submit completed application forms with the appropriate fees to:

Director
Certificate of Need and Acute Care Licensure
PO Box 360
John Fitch Plaza
Trenton, NJ 08625-0360

2. All applicants shall submit an application fee, which is non-refundable, as follows:

i. Except as (b)2ii below applies, the applicant shall remit a fee totaling $500.00 plus $3.00 for each bed for which the facility will be licensed, not to exceed $2,000 total for any single license.

ii. If the facility will be operated by a licensed hospital as a separate service, the applicant hospital shall remit a total fee of $150.00 for the filing of an application for a single license.

3. Each facility shall be assessed a biennial inspection fee of $500.00. This fee shall be assessed in the year the facility shall be inspected, along with the annual licensure fee for that year. The fee shall be added to the initial licensure fee for new facilities. Failure to pay the inspection fee shall result in non-renewal of the license for existing facilities and the refusal to issue an initial license for new facilities. This fee shall be imposed only every other year even if inspections occur more frequently and only for the inspection required to either issue an initial license or to renew an existing license. It shall not be imposed for any other type of inspection.

(c) An application form shall not be considered complete until the facility submits the licensing fee and the following:

1. The category designations for which the facility is to be licensed (that is, non-hospital based detoxification facility, long-term residential treatment facility including therapeutic communities, short-term residential treatment facility, halfway house, extended care facility), and a statement whether the patient population to be served will be adult-only, juvenile-only or both adult and juvenile and whether or not males and females or males or females only will be served at the facility. Applicants proposing to provide multiple levels of care within a facility shall designate the number of beds for each level of care and shall document that the facility meets the appropriate staffing and other requirements applicable to each level of care to be provided.

   i. If an applicant for residential substance abuse treatment facility licensure does not fit into any of the categories specified in (c)1 above, in the applicant's opinion, because treatment provided shall be new or otherwise innovative, the applicant shall so indicate this on the application, and shall submit a complete program description with the application, including, at a minimum:

      (1) The target population;

      (2) The services to be offered;

      (3) The frequency of counseling sessions;

      (4) The criteria and/or credentialing for staff,

      (5) The relationship to existing programs provided by the applicant; and

      (6) A proposed licensing category.

2. A clear demonstration of the applicant's ability to operate a facility in compliance with all of the rules of this chapter, as they apply to the category of residential substance abuse treatment facility specified by the applicant as the category for licensure;

3. Documentation of the ownership of the physical plant and property on which it is, or is to be, located;

4. The applicant's prior history in operating a facility in this State or elsewhere, with the historical data separated by category of facility operated, including data relevant to:

   i. Construction and maintenance of the physical plant(s) and equipment;

   ii. Staffing patterns, criteria and/or credentials thereof, including contract arrangements with outside agencies;

   iii. Make-up and criteria for any governing bodies;

   iv. Standards for engaging all other principals and management;

v. Financial arrangements and operation;

vi. Policies, standard operating procedures or institutional rules applicable to the operation of the residential substance abuse facility(ies);

vii. State or local rules applicable to the licensing and day-to-day operation of the facility(ies), if other than located outside New Jersey; and

viii. A record of penalties or fines assessed against the facility(ies) and its ownership relative to the operation of the facility(ies), or which may otherwise be considered relevant to the safety of patients of a facility and the community in which it is located, leveled by the State or a court of competent jurisdiction.

(d) Applications for licensure of newly constructed or expanded facilities shall include the following:

1. If the applicant intends to construct a new physical plant for the facility, or alter, renovate or expand a current physical plant, evidence of written approval, in accordance with N.J.A.C. 8:43E, of the plans and final construction from the:

Director
Health Care Plan Review
Department of Community Affairs
PO Box 815
Trenton, NJ 08625-0815; and

2. A proposed plan of operation or set of by-laws for the governing authority of the facility.

**8:42A-2.2 Review and approval of a license application**

(a) If the application is incomplete, the Department shall notify the applicant in writing of the missing information, and the applicant shall be permitted to address any deficiency in the application.

(b) When the application is complete, the Department shall review the application to determine whether the applicant is fit and adequate to operate a facility, as demonstrated by the information contained in the application, and obtained from other state agencies in this State and others, necessary for the Department to make a knowledgeable decision.

1. The Department may schedule a preliminary conference with the applicant for review of the conditions for licensure and operation as the Department determines is necessary.

2. If the Department does not schedule a preliminary conference, the applicant can request a preliminary conference.

3. The Department shall schedule a survey of the proposed facility when the building is ready for occupancy to determine if the facility complies with this chapter.

i. The Department shall notify the applicant in writing of the findings of the survey, including any deficiencies.

ii. If the Department documents deficiencies, the Department shall schedule additional surveys of the residential substance abuse treatment facility prior to occupancy only after the applicant notifies the Department that documented deficiencies have been corrected.

(c) The Department shall approve a complete application for licensure if:

1. The Department is satisfied that the applicant and its description of the facility physical plant, finances, hiring practices, management, ownership, operational procedures, and history of prior operations, if any, represent no substantial risk of harm to the safety, treatment and general welfare of the patient, and families of patients;

2. Surveys of the facility document no deficiencies, or document adequate correction of all deficiencies previously documented;

3. The applicant has provided the Department with written approvals for the facility from the local zoning, fire, health and building authorities; and

4. The applicant has provided the Department with written approvals for the facility from the local authorities or local official for the water supply and sewage disposal system for any water supply or sewage disposal system not connected to an approved municipal system.

(d) In no instance shall any applicant admit patients to the facility until the Department issues a license to the applicant for that facility.

**8:42A-2.3 Licenses**

(a) A license shall not be assignable or transferable, and shall be immediately void if the facility ceases to operate, relocates, or if its ownership changes.

(b) A license shall be granted for a period of one year (12 consecutive months), and shall be eligible for annual renewal on and up to 30 days following the license anniversary date (with each renewal dated back to the license anniversary date) upon submission of the appropriate fee, so long as the license has not been suspended or revoked by the Department, and the facility otherwise continues to be in compliance with all local rules, regulations and other requirements.

1. Except as set forth in (b)2 below, the renewal licensure fee for a facility shall be the total of $500.00 plus $3.00 per bed for which the facility is licensed, not to exceed $2,000.

2. The renewal licensure fee for a facility operated by a licensed hospital as a separate service shall be $150.00.

(c) The license shall be conspicuously posted in the facility at all times.

**8:42A-2.4 Periodic surveys following licensure**

(a) The Department shall make survey visits of a facility from time to time, announced or unannounced.

(b) Survey visits may include, but shall not be limited to:

1. Review of the physical plant and architectural plans;

2. Review of all documents and patient records;

3. Conferences with patients and staff, and

4. Review of all other components covered by this chapter.

(c) In addition to periodic surveys, the Department may make surveys as necessary to investigate complaints of possible licensure violations, from whatever source received, regarding the facility, patients, or staff.

(d) Information identifying patients shall be kept confidential by the Department at all times.

**8:42A-2.5 Surrender of a license**

(a) When a facility elects to voluntarily surrender a license, it shall provide written notice of its intention, and the specific date on which it shall surrender its license, as follows:

1. The facility shall provide the Department with at least 45 days prior notice;

2. The facility shall provide each patient and the physician(s) for each patient with at least 30 days prior notice, and

3. The facility shall provide each guarantor of payment at least 30 days prior notice.

(b) When a facility is ordered by the Department to surrender its license, it shall provide written notice of the surrender as required by (a)2 and 3 above, unless the order sets forth other or additional notice requirements.

(c) All notices to the Department regarding voluntary surrender of a license, and the physical license, shall be sent to the address set forth at N.J.A.C. 8:42A-2.1(b)l.

1. The facility shall forward the license to the Department in a manner that assures that the license will be received by the Department within seven days of the date established for surrender of the license.

**8:42A-2.6 Waiver**

(a) An applicant for licensure or licensee may seek, and the Department shall grant, a waiver of one or more provisions of this chapter, if the applicant or licensee demonstrates that compliance represents an unreasonable hardship for the applicant or licensee, and such a waiver is determined by the Department to be consistent with the general purposes and intents of N.J.S.A. 26:2H-1 et seq., and N.J.A.C 8:42A, is in the public interest, and would not otherwise endanger the life, safety, health or welfare of the patient populations to be served, their families, personnel who work or would work at the facility, or the public.

(b) An applicant or licensee seeking a waiver shall submit the request in writing to the address set forth at N.J.A.C. 8:42A-2.1(b), and shall include the following:

1. The specific rule(s) from which waiver is requested;

2. The specific reasons which justify the waiver, including a statement of the type and degree of hardship that would result to the applicant or licensee if the waiver were not granted;

3. An alternative proposal to ensure safety of patients and personnel, patient families, and the public, as appropriate;

4. Specific documentation to support the waiver request and all assertions made in the request;

5. A statement addressing how the waiver would fulfill the purpose and intent of N.J.S.A. 26:2H-1 et seq. and this chapter; and

6. Such other additional information that the Department may determine is necessary and appropriate for evaluation and review of the waiver request on a case by case basis.

**8:42A-2.7 Enforcement**

The Department shall enforce the requirements of this chapter in accordance with the applicable provisions of N.J.A.C. 8:43E.

**8:42A-2.8 Hearings**

(a) To effect a hearing request in accordance with N.J.A.C. 8:43E-4.1, the hearing request shall include:

1. The name, address and location (if different), license number of the facility and other identifying information;

2. The date of the Department's notice of action;

3. An enumeration of the items in the notice of action that are disputed; and

4. A brief explanation of the facts and/or law supporting the contention that the Department's action is incorrect or inappropriate.

(b) An attempt, if any, to resolve the matter amicably prior to transmittal of a hearing request to the Office of Administrative Law shall be made in accordance with N.J.A.C. 8:43E-4.2, except that a pre-hearing conference in this regard may be requested by either the Department or the party against whom the action is pending.

## SUBCHAPTER 3. GENERAL REQUIREMENTS

### 8:42A-3.1 Provision of services

(a) A residential substance abuse treatment facility shall provide medical and nursing services (including treatment, diagnostic, therapeutic, and preventive services), counseling, vocational, educational and other support services, directly or by written contract with a third party provider as specified for each category of residential substance abuse treatment facility set forth in this chapter.

1. If the facility contracts with a third party provider, the written agreement shall specify each party's responsibilities.

2. If the service is provided in the facility, the written agreement shall require that services be provided in accordance with the rules in this chapter.

3. If the service is provided outside of the facility, the written agreement shall require the provision of written documentation to the facility, including, but not limited to, documentation of services rendered and recommendations made by the party providing the service.

### 8:42A-3.2 Compliance with laws and rules

(a) The facility shall comply with all applicable Federal, State, and local laws, rules, and regulations.

(b) If a licensee provides residential substance abuse treatment services in addition to other health care services, the licensee shall comply with the rules in this chapter and all other applicable rules and regulations.

### 8:42A-3.3 Ownership

(a) The licensee for a facility shall be held responsible by the Department for assuring that the facility is and remains in compliance with all applicable statutes, rules and regulations related to the construction and maintenance of the physical plant, regardless of whether the licensee owns the physical plant or not.

(b) Facilities in which ownership of the physical plant, and/or the property on which it is located is by an entity other than the licensee for the facility, shall provide notice of the current ownership of the property(ies), upon request.

1. Notice of ownership may be maintained at the facility, or at a separate designated location.

2. The facility shall provide the Department written notice of any change in ownership of the physical plant or land on which it is located at least 30 days prior to such change, at the address set forth at N.J.A.C. 8:42A-2.1(b)1.

(c) At no time shall any person convicted of a crime relating adversely to the person's ownership, operation or management of a facility, own, operate or manage a facility.

**8:42A-3.4 Submission of documents and data**

The facility shall, upon request, submit to the Department any documents required by this chapter to be maintained by the facility. Information identifying patients shall be kept confidential at all times by the Department.

**8:42A-3.5 Personnel**

(a) The facility shall maintain personnel records for each employee, including, at a minimum, the employee's name, previous employment, educational background, credentials, professional license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, record of voluntarily disclosed criminal convictions, records of physical examinations, job descriptions, records of staff orientation and staff education, and evaluations of performance.

(b) The facility shall establish written policies and procedures addressing the period of time during which former substance abusers (alcohol, nicotine and/or drugs) shall be continuously substance free before being employed in the facility.

1. Staff shall not use alcohol, tobacco or illegal drugs during working hours or when representing the treatment facility.

(c) The facility shall develop written job descriptions and ensure that personnel are assigned duties based upon their education, training and competencies, and in accordance with their job descriptions.

(d) With respect to personnel who require licensure, certification, or authorization to provide patient care, the facility shall employ and continue employment for only those personnel who are licensed, certified, or authorized under the appropriate laws or rules of the State of New Jersey or under the applicable standards of the appropriate recognized credentialing body.

(e) The facility shall implement staff schedules that ensure continuity of care to patients, and provide that substitute staff with equivalent qualifications are available to replace absent staff members such that adequate staffing levels are maintained.

(f) Facilities shall maintain a ratio of staff to patients of at least the following:

1. Notwithstanding the counselor to patient ratios specified in N.J.A.C. 8:42A-10.1, facilities serving adults shall have at least one staff member responsible for the supervision of each 20 adult patients during waking hours, and at least one staff member responsible for each 30 adult patients during sleeping hours except that during waking or sleeping hours no less than two staff shall be present at all times. Halfway houses serving 30 or fewer clients shall have at least one staff member on duty during waking and sleeping hours.

2. Facilities serving adolescents shall have at least one staff member responsible for the supervision of each 10 adolescent patients during waking hours and at least one staff member responsible for the supervision of each 20 adolescent patients during sleeping hours except that during waking or sleeping hours at least two staff members shall be present at all times.

3. Non-counseling staff responsible for supervision during day or evening hours shall, at a minimum:

i. Be 18 years of age;

ii. Possess a high school or high school equivalency diploma; and

iii. Have one year of experience working in a substance abuse treatment facility.

4. Facilities serving women and children shall meet the staff to patient ratios specified in f (1) above for adults for the women and shall provide the following ratio of staff to children at all times when the children are not under the direct care of their mothers:

i. At least one staff member for every five children under 2 ½ years of age and one staff for every 10 children ages 2 ½ to six during waking hours;

ii. At least one staff member for every 10 children under 2 ½ years of age and one staff for every 20 children ages 2 ½ to six during rest or sleeping hours; and

iii. When children of mixed ages requiring different staff member/child ratios are in one room or area within a large divided room, the agency shall compute the staff member/child ratios applicable for each group separately to the nearest tenth decimal. If the resulting cumulative figure for both age groups is any fraction above a whole number, an additional staff member shall be required.

(g) The facility shall develop and implement a staff orientation plan and a staff education plan, including plans for each service and designation of person(s) responsible for training.

1. All personnel shall receive orientation at the time of employment and at least annual in-service education regarding, at a minimum, emergency plans and procedures, the infection prevention and control program, universal precautions, policies and procedures concerning confidentiality, patient rights, and, if appropriate given the patient population of the facility, identification of cases of child abuse and/or elder abuse.

(h) At least one person who is certified in basic cardiac life support by the American Heart Association, the American Red Cross, the National Safety Council, or certified by the Department as an emergency medical technician (EMT), shall be in the facility at all times during its hours of operation.

**8:42A-3.6 Policy and procedure manual**

(a) The facility shall develop, implement and review at least annually a policy and procedure manual(s) for the organization and operation of a residential substance abuse treatment facility which policy and procedure manual(s) shall be maintained on-site at the facility and available for review at all times by patients, staff and the public.

(b) The facility shall include at least the following in the policy and procedure manual(s):

1. A written statement describing the program's treatment philosophy, objectives, and staffing patterns, and the services provided by the facility;

2. An organizational chart delineating the lines of authority, responsibility, and accountability for the administration and patient care services of the facility;

3. Policies regarding the facility's definition of "business hours," "full-time" and "shift";

4. A description of the quality assurance program for patient care and staff performance, including methods for at least annual review of staff performance, staff qualifications and credentials, and staff orientation and education;

5. Policies and procedures for the confidential maintenance of patient records while the facility is in operation and in the event that it ceases to operate;

6. A description of the modalities of treatment provided, including a listing of services and procedures which may be performed in the facility;

7. A written plan for informing persons in need of substance abuse treatment services, co-dependents, the public, and health care providers of the availability of the facility's services, including a description of referral mechanisms and linkages with consultants, other health care facilities, law enforcement, social and community agencies that will provide continuity of care for patients and designation of staff responsible for implementation of the plan;

8. Policies and procedures for making information about alcohol, tobacco and other drug use and abuse available to the public;

9. Policies and procedures to assure the accessibility of telephone(s) for use by patients and policies governing the use of such telephones by patients;

10. Policies and procedures for answering and responding to incoming phone calls at times other than designated business hours.

    i. If an answering machine or answering service is used in the facility, policies must assure that messages are checked at least once every hour;

11. Policies and procedures addressing the use of sanctions or punishments in the program.

    i. In juvenile programs, the following practices are expressly forbidden:

        (1) Use of corporal punishment;

        (2) Use of restraints of any sort; and

        (3) Use of a behavior management room, unless such a room is permitted and regulated under the auspices of the Department of Human Services, Division of Youth and Family Services.

12. Policies and procedures for complying with applicable statutes and regulation to report child abuse and/or neglect, abuse or mistreatment of elderly or disabled adults, sexual abuse, sexual assault, specified communicable diseases, including HIV infection, rabies, poisonings, and unattended or suspicious deaths. These policies and procedures shall include the following:

    i. The designation of a staff member(s) to be responsible for coordinating the reporting of diagnosed and/or suspected cases of child abuse and/or neglect in compliance with N.J.S.A. 9:6-1 et seq., recording the notification to the Division of Youth and Family Services in the clinical record, and serving as a liaison between the facility and the Division of Youth and Family Services;

ii. The protocols for notification of any suspected case of patient abuse or exploitation to the State of New Jersey Office of the Ombudsman for the Institutionalized Elderly, pursuant to N.J.S.A. 52:27G-7.1 et seq., if the patient is 60 years of age or older;

iii. The protocols for the identification and treatment of children and elderly or disabled adults who are abused and/or neglected; and

iv. The provision at least annually of education and/or training programs to appropriate persons regarding the identification and reporting of diagnosed and/or suspected cases of child abuse and/or neglect, sexual assault or abuse, domestic violence, abuse of the elderly or disabled adult, and the facility's policies and procedures.

13. Policies and procedures governing the delivery of services in the facility including, at a minimum, the following:

i. Policies governing the frequency of counseling interventions and didactic sessions;

ii. Policies governing the content of didactic sessions, including a written description or curriculum of didactic sessions offered in the facility; and

14. Policies and procedures to ensure that physical examinations of employees are performed upon employment and subsequently, and specifying the circumstances under which other persons providing direct patient care services shall receive a physical examination.

i. Policies and procedures shall specify the content and the frequency of the examinations.

(c) The facility shall require all employees employed as of November 15, 1999 and all employees hired thereafter to submit to screening tests for rubella and measles, subject to the following:

1. If an employee can document seropositivity from a previous rubella screening or inoculation with rubella vaccine, the employee shall not be required to submit to any additional rubella screening.

2. If an employee cannot provide documentation required by (a)l above, the employee shall be given a rubella hemagglutination inhibition test or other rubella screening test approved by the Department as equivalent or better, on a case-by-case basis. (See N.J.A.C. 8:57-4.)

3. Only employees born in 1957 or later shall be required to submit to a measles screening test.

i. If the employee can document receipt of a live measles vaccine on or after his or her first birthday, physician diagnosed measles, or serologic evidence of immunity to measles, the employee shall not be required to submit to a measles screening test.

ii. If the employee cannot provide the documentation required in (c)3i above, the employee shall submit to a measles hemagglutination inhibition test, or other measles screening test.

4. All employees hired after November 15, 1999 required to submit to screening tests shall do so upon employment.

5. All employees employed as of November 15, 1999 required to submit to screening tests shall do so by May 15, 2000.

(d) The facility shall inform each employee of the results of each screening test, record all tests performed and the results thereof in each employee's personnel record, and maintain a list of all employees who are seronegative and unvaccinated.

(e) The facility shall require all employees, including medical staff members, to submit to tuberculosis testing using a Mantoux test with five tuberculin units of purified protein derivative, subject to the following:

1. Employees hired after November 15, 1999 shall be required to submit to Mantoux testing upon employment, while employees employed as of November 15, 1999 shall submit to the Mantoux test by May 15, 2000.

2. If the Mantoux test result is negative (less than 10 millimeters of induration or less than five millimeters of induration if immunosuppresed), the employee shall submit to a repeat mantoux skin test within three weeks of the initial test.

3. If either the initial or subsequent test result is positive (10 or more millimeters of induration, or five millimeters if immunosuppressed), the employee shall submit to a chest x-ray and be offered chemoprophylaxis or treatment for tuberculosis, as necessary.

4. Employees who can document a negative Mantoux test, within the prior 12 months would only need one Mantoux skin test.

5. Reserved.

6. Reserved.

7. The following employees shall not be required to submit to a Mantoux test:

i. Employees who can document a positive Mantoux skin test (10 millimeters or more of induration or five millimeters or more of induration if immunosuppressed) with chemoprophylaxis or medical treatment for tuberculosis as appropriate to the underlying cause for the positive result;

ii. Employees who have received and completed treatment for tuberculosis disease; and latent tuberculosis infection;

iii. Employees for whom a Mantoux skin test is medically contraindicated.

(f) The facility shall establish policies and procedures regarding employee safety and shall include procedures for the care of employees who become ill or who are injured at the facility.

**8:42A-3.7 Reportable events**

(a) The facility shall notify the Department immediately at 1-800-792-9770 and the Division of Addiction Services at (609) 292-5760 during normal business hours of any event occurring within the facility which jeopardizes the health or safety of patients or employees, including, but not limited to, the following:

1. All fires, floods, disasters, accidents, or other unanticipated events which result in serious injury or death of patients or staff, or evacuation of patients from the facility, or in closure of the facility for six or more hours;

2. All deaths of patients occurring in the facility;

3. Occurrence of communicable disease in the facility;

4. All alleged or suspected crimes which endanger the life or safety of patients or staff, and

5. Any disciplinary action, including termination, resulting from inappropriate staff interaction with patients.

(b) All patients admitted to and discharged from the facility shall be reported to the Division of Addiction Services monthly on the Alcohol and Drug Abuse Data System (ADADS).

(c) The facility shall confirm events reported by telephone to the Department in writing within 24 hours of the event, unless the Department determines that a written report is unnecessary. The written confirmation shall contain information concerning injuries to patients or staff, disruption of services, extent of damages, and corrective actions taken by the facility.

(d) The facility shall notify the Department in writing of the resignation or termination of employment of the administrator or the director of substance abuse counseling services and the name and qualifications of the replacement, no later than seven days following the date of resignation or termination.

**8:42A-3.8 Notices**

(a) The facility shall conspicuously post a notice that the following information is available in the facility during its normal business hours for patients and the public:

1. All waivers granted by the Department;

2. The list of deficiencies from the last annual licensure inspection, and the list of deficiencies from any valid complaint investigation during the past 12 months;

3. A statement of patient rights;

4. The names of members of the governing authority of the facility and the addresses to which correspondence may be sent; and

5. The hours of operation and the normal business hours of the facility.

**8:42A-3.9 Reporting to professional licensing boards**

The facility shall comply with all requirements of the professional licensing boards for reporting termination, suspension, revocation, or reduction of privileges of any professional licensed in the State of New Jersey.

**8:42A-3.10 Transportation**

(a) The facility shall develop and implement a method of patient transportation for services provided outside the facility, which shall include plans for security and accountability for the patient and his or her personal possessions, as well as transfer of patient information to and from the provider of the services.

(b) The facility shall maintain, or otherwise assure that, all vehicles used for transportation of patients are in conformity with all motor vehicle and insurance laws and/or regulations.

1. The facility shall maintain copies of registration and insurance information for all vehicles used to transport patients.

2. The facility shall keep on file the name of each driver and a photocopy of his or her driver's license.

**8:42A-3.11 Tobacco products**

(a) The smoking of tobacco products and the use of spit tobacco is prohibited within all buildings. The use of tobacco products and spit tobacco on the grounds of freestanding treatment facilities shall be phased out by November 15, 2001.

(b) Tobacco products shall not be used in vehicles used to transport patients at any time.

## SUBCHAPTER 4. GOVERNING AUTHORITY

### 8:42A-4.1 Responsibility of the governing authority

(a) Every residential substance abuse treatment facility shall have a governing authority which shall assume legal responsibility for the management, operation, and financial viability of the facility.

(b) The governing authority shall act in accordance with a plan of operation or by-laws that shall set forth policies and procedures for its conduct and oversight of the operation of the residential substance abuse treatment facility, including the:

1. Composition of the governing authority, qualifications of members and officers, procedures for election or appointments to seats (including mid-term vacancies), terms of service;

2. Establishment of standing and ad hoc committees, their duties and powers, terms of chairpersons and qualifications for chairpersons and members of committees;

3. Methodology by which the governing authority shall approve by-laws, policies and procedures required to be maintained by the facility under this chapter and revision hereto and documentation of such approval;

4. Establishment of schedules for review of all policies, procedures and by-laws of the facility;

5. Establishment of the methodology by which books and records shall be maintained, consistent with the standards of this chapter, schedules for regular audits, both internal and independent, and the basis for spot audits by independent sources;

6. Delineation of those services that shall be provided through written agreement;

7. Delineation of a grievance procedure for staff and patients; and

8. Methodology by which the plan of operation or by-laws shall be amended by the governing authority.

(c) The governing authority shall:

1. Document all of its actions and those of the committees by written minutes;

2. Establish a grievance mechanism available to both staff and patients;

3. Establish a feedback mechanism in order to receive and respond to staff and patient recommendations;

4. Establish a notice system accessible to all staff and patients regarding the grievance procedures;

5. Appoint an administrator for the facility, and approve a person to be designated as the administrator's alternate, in writing;

6. Establish an annual budget for all services to be provided at or through the facility in consultation with the administrator and the service directors;

7. Establish a patient care policy committee;

8. Establish a pharmacy and therapeutic committee if so required at N.J.A.C. 8:42A-14; and

9. Establish an infection control committee.

## SUBCHAPTER 5. ADMINISTRATION

### 8:42A-5.1 Appointment of administrators

The governing authority shall appoint an administrator who shall be accountable to the governing authority. The administrator, or an alternate who shall be designated in writing to act in the absence of the administrator, shall be available in the facility at all times.

### 8:42A-5.2 Administrator's responsibilities

(a) The administrator shall be responsible for at least the following:

1. Ensuring the development, implementation, and enforcement of all policies and procedures as required under this chapter, including patient rights;

2. Planning for, and administration of, the managerial, personnel, operational, fiscal, and reporting responsibilities of the facility;

3. Participating in the quality assurance program for patient care;

4. Participating in the determination of staffing issues including, but not limited to, assessment of staff performance, employment and termination decisions and credentials review;

5. Ensuring that all personnel are assigned duties based upon their education, training, competencies, and job description;

6. Ensuring the provision of staff orientation and staff education;

7. Establishing and maintaining liaison relationships and communication with facility staff and service providers, with support service providers and community resources, and with patients;

8. Overseeing the implementation of policies and procedures, in conjunction with designated staff members, for the various services provided for in this chapter;

9. Ensuring that admission interviews with patients and in the case of juveniles, the patient's family, guardian or legally authorized representative, be conducted in accordance with established policies and procedures;

10. Implementing and monitoring the quality of all services provided at the facility, including educational and vocational services and recreational services;

11. Assuring maintenance of the physical plant as necessary to assure patient and staff safety, and otherwise keeping the facility within all applicable building, fire and safety codes;

12. Establishing policies and procedures for provision of emergency services to patients, and policies and procedures for other broader-based emergency situations resulting from both internal incidences and natural disaster;

13. Development and implementation of an infection prevention and control program; and

14. Development and implementation of a volunteer services program, if the facility elects to incorporate such a program.

## SUBCHAPTER 6. PATIENT CARE POLICIES AND SERVICES

### 8:42A-6.1 Patient care policy committee

(a) Every residential substance abuse treatment facility shall establish a patient care policy committee to:

1. Develop all patient care policies and procedures of the facility consistent with the requirements of this chapter;

2. Review the facility's policies and procedures periodically, but no less than annually; and

3. Review any incident occurring in the facility that may reflect upon the adequacy of policies and procedures with respect to the health and safety of patients.

(b) The patient care policy committee shall be composed of at least the administrator, the medical director, if the facility is required to have a medical director or otherwise engages one, the Director of Substance Abuse Counseling, and a representative of nursing services.

(c) The patient care policy committee shall document its meetings, items discussed and actions taken.

(d) When developing and reviewing policies and procedures regarding a specific service, the patient care policy committee shall invite representatives of the respective service providers to attend the meetings in which the specific services are being discussed, and shall actively solicit input from the service provider representatives.

(e) The patient care policy committee shall develop policies and procedures for the care of the general patient population, and which also address the needs of any special populations that the facility shall serve including women, pregnant women, juveniles, people of color, people who are homeless and indigents.

(f) In addition to addressing specific patient care policies and procedures, the patient care policy committee shall address the facility's plan and policies for separate housing of adults and juveniles, as well as male and female patients.

### 8:42A-6.2 Patient care policies and procedures

(a) The patient care policy committee shall establish patient care policies and procedures that facilitate continuity of care to patients and contribute to an effective treatment environment, addressing at least the following subjects:

1. Patients' rights;

2. Staffing patterns;

3. Referral of patients to health care providers outside of the facility;

4. Emergency care of patients;

5. Care of patients during an episode of communicable disease;

6. Care of patients with tuberculosis which is not transmissible, or no longer communicable;

7. Informed consent requirements and methodology, including provisions for obtaining informed consent from parents or guardians of juveniles;

8. Health education of patients through various mediums, including written, and presented multilingually on the basis of patient composition of the facility;

9. Criteria for discharge, transfer and readmission of patients from the facility;

10. Responsibility of the facility with respect to patient care and supervision off-site, including who may accompany patients, and the destinations for patients or classes of patients;

11. Care and control of pets when pets are permitted at the facility;

12. Provision of clothing for patients that is suitable for season and size, and reasonably compatible with that worn by the patient's peers when clothing is provided by the facility;

13. Housekeeping activities that patients may be assigned as part of the patient treatment plans, when appropriate to the category of facility;

14. Evaluation of patients for substance use through random urinalysis on grounds that are reasonable and not unfairly discriminatory. (For example, all patients that temporarily leave the residential substance abuse treatment facility may be subject to random urinalysis upon return to the facility); and

15. Care of deceased patients, including notification of local law enforcement, removal of a deceased patient from rooms occupied by other patients, removal of a deceased patient from the facility in a safe and dignified manner, pronouncement of death and notification of the deceased patient's family.

    i. The facility shall not discharge a deceased patient until that patient is pronounced dead, and the death has been documented in the patient's clinical record.

    ii. The facility shall notify the deceased patient's family, legal guardian, or legally authorized representative immediately upon the pronouncement of death, if the family, legal guardian or legally authorized representative is not present at the time of the patient's death.

(b) The patient care policy committee shall establish policies and procedures regarding financial arrangements established between patients and the facility, including:

1. The method and time frames for retention of records of financial arrangements and transactions.

    i. The facility shall provide patients with copies of all financial arrangements and transactions relevant to the patient.

2. The method by which patients shall be informed of the fees charged by the facility, for the type of service and supplies provided prior to the provision of any such service, as follows:

    i. At a minimum, the facility shall post a notice that a fee schedule is available for review on-site upon request, which notice shall include a statement that physician and other provider fees shall be billed separately, if that is the case.

ii. At a minimum, the facility shall require physicians and other providers of services to its patients to disclose to its patients whether there are separate charges for the services provided upon the request of the patient.

iii. Facilities that provide for sliding fee scales or special payment plans, at a minimum, shall provide notice to patients that a description of the sliding fee scales, or special payment arrangements, and the circumstances in which the sliding fee scales or special payment plans may be appropriate, is available on-site for review upon request of a patient.

3. The fee schedule for the provision of services for which the facility shall or may charge as follows:

i. The facility shall not assess charges, expenses or other financial liabilities in excess of those established in the fee schedule without the written approval of the patient, except in the event of an emergency which requires that the patient be provided with special services or supplies.

(1) The facility shall provide the patient written copies of all of his or her approvals of additional expenses, or expenses incurred in rendering services to the patient during an emergency.

4. The method for notifying patients regarding the facility's agreements with insurance companies, health maintenance organizations and other third-party payers; and

5. The method for notifying patients regarding sources of financial assistance available to patients, and the method for referring patients directly to the source(s) of financial assistance, when appropriate.

(c) The patient care committee shall establish policies and procedures for the process of intervention, if the facility participates in the intervention process, setting forth at least the responsibilities of staff and the information required to be documented regarding the process of intervention.

(d) The patient care committee shall establish policies and procedures for the acceptance of verbal and telephone orders.

1. Verbal and telephone orders shall be limited to emergency situations.

2. Verbal and telephone orders shall be written into the patient's clinical record by the person receiving such orders, and countersigned by the person issuing such orders within 24 hours of the issuance of the verbal or telephone order.

(e) The patient care committee shall establish policies and procedures for providing notifications in various situations to families of patients (which shall be entered in the patient's clinical record), including the following situations:

1. Patient injury requiring medical care;

2. Accidents or incidents involving the patient;

3. Patient transfer; and

4. Patient death.

**8:42A-6.3 Standards for admission and retention of patients**

(a) The facility shall interview all patients and, in the case of juveniles, his or her family, guardian or legally authorized representative prior to or at the time of admission of the patient, a summary of which shall be documented in the patient clinical record.

1. The interview shall include orientation of the patient to the facility's policies, business hours, fee schedules, services provided, patient rights, criteria for admission, treatment and discharge.

2. The facility shall obtain informed consent from the parents or legally authorized representative of a juvenile prior to that juvenile entering treatment.

3. If admission is denied, the facility shall provide the reasons for denial in writing, to the person being denied admission and signed by the administrator, within 15 days following the date of the interview.

(b) A facility shall not admit:

1. An individual who is unconscious at the time of presentation, but shall transfer such an individual immediately to a hospital; or

2. An individual who manifests such a degree of behavioral disorder that the individual is a danger to himself or herself or others, or whose behavior interferes with the health or safety of staff or other patients.

(c) A facility licensed to provide services to juveniles shall admit juveniles only to areas within the facility approved for juvenile occupancy by the Department, as part of the licensure process.

1. Areas for juveniles shall be physically separated from and have restricted access to any part of a facility occupied by or accessible to adult patients.

(d) Only facilities licensed by the Department to provide medically monitored detoxification services or hospitals providing medical detoxification services in a designated detoxification unit or facility shall admit patients requiring medically monitored detoxification.

(e) A facility shall admit patients that manifest one or more disabilities only to appropriate rooms within the facility.

1. Patients who are blind or who can walk independently only with crutches shall be housed on the first floor of the facility, if the facility is not constructed of fire-resistive materials.

2. Patients in wheelchairs shall only be housed on the first floor of the facility. Facilities that have received physical plant waivers from the Department shall not admit patients in wheelchairs unless the waivers request and the approval granted by the Department specifically indicates the circumstances under which patients in wheelchairs may by admitted to the facility.

(f) Upon admission, the facility shall assure that each patient has received a physical examination. In addition, a physician shall certify that the patient is:

1. Free of communicable disease or, if a patient had a communicable disease, that the patient is treated, or, if the disease is not curable, that the patient is managed to prevent transmission to other patients;

2. Mobile under his or her own power with or without assistive devices; and

3. Able to leave the building alone, except in a facility licensed to provide medically monitored detoxification services.

(g) A facility shall not involuntarily admit or retain any patient.

(h) A facility shall not retain any patient who manifests such a degree of behavioral disorder that the patient is a danger to himself or herself or others, or whose behavior interferes with the health and safety of staff or other patients.

**8:42A-6.4 Involuntary discharge**

(a) A facility shall have a written policy and procedure addressing the involuntary discharge of patients. If the patient is a juvenile, the patients' parent(s), guardian or legally authorized representative shall be provided with written notice of the facility's intent to discharge the patient.

1. The written notice shall include the specific reason(s) for the discharge, and shall set forth the patient's right and procedures to appeal the discharge decision.

(b) Patients shall have the right to appeal an involuntary discharge in accordance with procedures established by the facility. If the patient is a juvenile an appeal must be filed by the parent(s), guardian or legally authorized representative.

1. The residential substance abuse treatment facility shall require that the appeal be in writing.

2. A copy of the appeal, and the disposition thereof, shall be entered in the patient's clinical record.

(c) A facility may involuntarily discharge a patient without prior notice if the patient poses a health or safety hazard to himself or herself, other patients, or staff or otherwise violates facility policies which were presented to the patient at the time of admission.

**8:42A-6.5 Use of restraints**

(a) The facility shall not use any physical, chemical, or other type of restraint unless the facility is licensed by the Department to provide medical detoxification services.

1. If restraints are used, the facility shall develop and implement policies and procedures regarding their use including, at a minimum:

i. Specification of the uses of restraints and types of restraints permitted, specification of the frequency with which a patient placed in restraint shall be monitored and of the personnel responsible for monitoring the patient, and specification of the required documentation;

ii. Prohibition of the use of locked restraints and confinement of a patient in a locked or barricaded room, and prohibition of the use of restraints for punishment or for the convenience of facility personnel;

iii. Specification that restraints be used so as not to cause physical injury or discomfort to the patient and only when authorized for a specified period of time. Opportunity for motion and exercise shall be provided for a period of not less than 10 minutes during each one-hour period in which a physical restraint is employed, to ensure opportunity for elimination of body wastes, good body alignment, circulation, and change of position; and

iv. A requirement that a physical restraint be used only when authorized in writing by a physician except when necessitated by an emergency, in which case it shall be approved by the medical director or the director of nursing services or his or her designee.

**8:42A-6.6 Calibration of instruments**

The facility shall ensure that all instruments are calibrated in accordance with manufacturer's instructions, and shall maintain a record of maintenance for all instruments.

**8:42A-6.7 Interpretation services**

The facility shall provide interpretation services when necessary for patients who do not speak English or who are deaf, and other communication assistance as needed for patients who are blind if the facility admits persons who may require such assistance.

## SUBCHAPTER 7. MEDICAL SERVICES

### 8:42A-7.1 Provision of medical services

(a) Every residential substance treatment facility shall provide for the rendering of medical services to clients.

1. Hospital-based (medical) detoxification, non-hospital based (medical) detoxification facilities, short-term residential facilities, and long-term residential facilities including therapeutic communities shall designate a medical director who shall supervise the medical services provided, or supervise the coordination of the medical services provided.

   i. Hospital-based (medical) detoxification, non-hospital based (medical) detoxification facilities and short-term residential facilities shall provide for the rendering of medical services on site.

   ii. Long-term residential facilities including therapeutic communities may provide for the rendering of medical services on site or through written agreements with one or more physicians who provide services outside of the facility.

2. Extended care programs and halfway houses are not required to designate a medical director, but shall incorporate information regarding medical services rendered to a patient in the patient's treatment plan.

   i. Extended care programs and halfway houses shall establish agreements/contracts with physicians to provide medical services on site or outside the facility.

   ii. Extended care programs and halfway houses shall designate facility staff to serve as a medical liaison.

      (1) The medical liaison shall be responsible for incorporating medical information in patient treatment plans, and documenting all medical contacts in the clinical record.

   iii. Extended care programs and halfway houses shall obtain consent from each client for the release of information from the physician to the medical liaison.

(b) Facilities shall, for each patient intended to be admitted at the facility, perform, or have performed:

1. A physical examination of the patient that meets the standards of N.J.A.C. 8:42A-9.1 (b) prior to admission of the patient to the facility, unless there is documentation that such an examination and/or laboratory tests were performed within 30 days prior to the date or anticipated date of admission of the patient in the facility, in which instance, the physical examination requirements may be waived; and

2. An assessment of the patient for communicable disease prior to admission of the patient to the facility.

   i. A patient suspected of having a communicable disease shall not be admitted to the facility until the patient is determined to be free of communicable disease upon complete physical examination of the patient.

(c) Notwithstanding that a facility is required to provide medical services in accordance with (a) above, the facility may refer patients to physicians outside of the facility for additional medical services as are necessary to provide a continuum of care for the patient.

1. Facilities with juvenile patients shall provide notice to and obtain the consent for the rendering of medical services from the juvenile's parent, guardian, or legally authorized representative as the services are required.

(d) Facilities that are not required to and do not designate a medical director shall have a written policy and procedure regarding the provision or coordination of medical services, including detailed descriptions of how the facility shall assure performance of the responsibilities set forth in (a) above.

(e) Facilities serving women and children shall insure that children are age appropriately immunized at admission, show no signs of illness and have been receiving regular primary care prior to and continue to receive primary care as needed, during their stay at the facility.

**8:42A-7.2 Medical director**

(a) The medical director of the facility shall be responsible for the direction, provision, and quality of medical services provided to patients, and in so doing shall be responsible for at least the following:

1. Designating, in writing, a physician to act in the absence of the medical director, and assuring that either the medical director or the other designated physician is available to the facility at all times.

i. With respect to facilities that are licensed to provide medically monitored detoxification services, the medical director or designated physician shall be on-site seven days a week to review the status of all patients receiving detoxification services;

2. Assisting the administrator of the facility in the development and maintenance of written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for medical services, and at least an annual review of all medical policies and procedures.

i. The medical policies and procedures shall be developed in accordance with N.J.A.C. 8:42A-7.3;

3. In conjunction with the administrator and the governing body of the substance abuse facility, planning and budgeting for medical services;

4. Coordinating and integrating medical services with other patient care services to assure a continuum of care for each patient;

5. Ensuring that the facility complies with required medical staffing patterns;

6. Assisting in the development of written job descriptions for the medical staff, reviewing of credentials and delineation of privileges of medical staff, and assigning duties of the medical staff;

7. Participating in staff orientation and staff education activities;

8. Approving the content and location of emergency kits or carts, equipment and supplies, the expiration dates of such time-sensitive items, the frequency with which these items are reviewed for appropriateness and completeness, and assigning staff to perform these reviews; and

9. Reviewing the report of any physical exam conducted off-site of a patient being admitted to the facility, to ensure that the patient's medical needs are considered and addressed in the development of the treatment plan and throughout the treatment stay.

**8:42A-7.3 Medical policies and medical staff bylaws**

(a) The medical director, in conjunction with the medical staff of the facility, shall develop, implement and periodically review written medical policies, including medical staff bylaws, that shall be subject to the review and approval of the governing body of the facility.

(b) The written medical polic ies and bylaws shall include at least the following:

1. A plan for medical staff meetings, documented by minutes;

2. A procedure for reviewing credentials and delineating qualifications of medical staff, appointments and reappointments, evaluation of medical care, and the granting, denial, curtailment, suspension, or revocation of medical staff privileges;

3. Specifications for verbal orders, including who may give verbal orders and who may receive them;

4. A system for completion of entries in the patient clinical records by members of the medical staff, including specification of a time limit for completion of the clinical record, which time period shall not exceed 30 days following a patient's last treatment or discharge; and

5. For those facilities serving women and children, a plan for insuring that the medical needs of the children as well as the mothers, are adequately assessed and met during residence at the facility.

**8:42A-7.4 Physician responsibilities**

(a) Physicians that provide primary medical care to patients in a residential substance abuse treatment facility shall be responsible for:

1. Assuring the provision or documentation of a complete medical examination as required by N.J.A.C. 8:42A-9.1;

2. Ordering, interpreting and documenting drug screening, as appropriate;

3. Ordering, interpreting and documenting multiple screening tests, as appropriate;

4. Documenting all orders for services to be provided to the patient, including frequency and modality of treatment, therapies to be administered or coordinated, and medications prescribed;

5. Assuring that all medical interventions are documented in the clinical record; and

6. Assuring that medical follow-up of all acute or chronic illness and conditions is entered in the patient's treatment plan, that referrals for medical services are accomplished during the patient's treatment at the substance abuse facility, or as part of the patient's discharge plan, as appropriate.

(b) In facilities that provide medical services on-site, the physician shall assure that medical staff participate as part of the multidisciplinary treatment team, and shall document medical services provided via progress notes.

## SUBCHAPTER 8. NURSING SERVICES

### 8:42A-8.1 Provision of nursing services

(a) Every hospital based (medical) detoxification, non-hospital based (medical) detoxification facility, short-term residential facility, long-term residential facilities including therapeutic communities and extended care facility shall provide nursing services.

1. Hospital-based (medical) detoxification and non-hospital based (medical) detoxification facilities shall staff at least one registered nurse on each of its nursing units 24 hours a day, seven days a week.

2. Short-term residential facilities shall staff at least one registered nurse on duty eight hours a day Monday through Friday and shall have a registered nurse available at all other times.

3. Long-term residential facilities including therapeutic communities shall staff at least one registered nurse on duty at least eight hours per day, Monday through Friday, and shall have a registered nurse available at all other times.

4. Extended care facilities shall have nursing services on-site daily.

   i. Extended care facilities shall comply with N.J.A.C. 8:42A-8.3(a).

   ii. Extended care facilities that do not have nurses on staff shall provide nursing services through written contract.

5. Halfway houses are not required to have on-site nursing services but shall have a medical liaison who is responsible for insuring that the patient receives appropriate medical follow up as indicated in the pre-admission physical examination. In addition, there shall be follow up for any additional medical problems which occur during the stay within the facility.

6. Non-hospital based (medical) detoxification facilities, short-term residential facilities and long-term residential facilities including therapeutic communities shall provide additional licensed nursing personnel and ancillary nursing personnel in accordance with each facility's patient care policies and procedures for determining staffing levels.

### 8:42A-8.2 Director of nursing

(a) Every facility required to provide nursing services shall designate a director of nursing who shall be on the premises or available within 30 minutes during the facility's hours of operation.

(b) The director of nursing shall be responsible for the direction, provision and quality of nursing services provided to patients, and in so doing shall be responsible for the following:

1. Assisting the administrator of the facility in the development and maintenance of written objectives, policies and procedure manual, an organizational plan, and a quality assurance program for nursing service, and at least an annual review of all nursing policies and procedures;

2. In conjunction with the administrator and the governing body of the facility, planning and budgeting for nursing services;

3. Coordinating and integrating nursing services with other patient care services to assure a continuum of care for each patient;

4. Ensuring that the facility complies with required nursing staffing patterns;

5. Assisting in the development of written job descriptions for the nursing staff, and assigning duties of the nursing staff; and

6. Participating in staff orientation and staff education activities.

**8:42A-8.3 Responsibilities of licensed nursing personnel**

(a) Nursing care needs of patients shall be assessed only by a registered professional nurse.

(b) All nursing services provided shall be documented in the patient's clinical record, including at least the following:

1. The nursing portion of the patient care plan, in accordance with the facility's policies and procedures;

2. Clinical notes; and

3. A record of medications administered, including:

i. The name and strength of the medication;

ii. The date and time of administration;

iii. The dosage administered;

iv. Method of administration; and

v. Signature of the nurse who administered the medication.

## SUBCHAPTER 9. PATIENT ASSESSMENTS AND TREATMENT PLAN

### 8:42A-9.1 Patient assessment

(a) A residential substance abuse treatment facility shall provide, within 72 hours of admission, a bio-psychosocial assessment of all patients using the Addiction Severity Index, or a similar standardized assessment instrument approved by the Department, in order to assure that the patient is placed in the appropriate treatment program based on criteria defined in the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. (See N.J.A.C. 8:42A-1.3.)

1. If the bio-psychosocial assessment indicates that the patient should be referred to another treatment program, the facility shall coordinate the patient's referral.

(b) In performing a bio-psychosocial assessment, the facility shall assess the following:

1. The patient's medical, alcohol, tobacco, and drug history, and interventions, if any;

2. The results of the patient's physical examination, which shall include a certification by the examining physician that the level of medical care needed by the patient is available through the facility and the following laboratory tests and evaluations, subject to patient consent:

i. Blood work for chronic, incurable and other communicable diseases or conditions as indicated by the patient's medical history and the physician's evaluation;

ii. Serologic tests for syphilis, smears and cultures for gonorrhea and other sexually transmitted diseases, as medically indicated;

iii. Routine and microscopic urinalysis, including pregnancy testing for females;

iv. Human immunodeficiency virus HIV antibody testing, as medically indicated, for which the substance abuse facility shall obtain a separate consent. If HIV testing is performed onsite, the facility is required to report positive results according to N.J.A.C. 8:57-2.1 through 2.7 and maintain patient confidentiality according to N.J.S.A. 26:5C-7 et seq.;

v. All pregnant women shall be provided information on HIV and AIDS and offered testing for HIV infection. This may be provided by the administrator or delegated to another health care professional but such delegation of duties shall not relieve the administrator from the ultimate responsibility to see that this information is provided in accordance with N.J.A.C. 8:61-3. 1;

vi. Hepatitis B and Hepatitis C as medically indicated;

vii. A Mantoux tuberculin skin test with five tuberculin units of purified protein derivative, shall be re-administered no more than two weeks later to all patients who have a reaction of less than 10 millimeters of induration (not significant) between 48 and 72 hours following the initial administration, except that patients that have had one Mantoux tuberculin skin test within six months prior to the current admission to the substance abuse facility shall only be required to submit to one such test; and

viii. Mantoux tuberculin skin testing with five units of purified protein derivative shall be administered to all patients upon admission to the facility. Initial testing shall be done using the two-step Mantoux skin testing;

ix. If the first step of the Mantoux tuberculin skin test is negative (less than 10 millimeters of induration or less than five millimeters of induration if immunosuppressed), the second step of the two-step Mantoux test shall be administered within three weeks;

x. A patient who can document a negative Mantoux tuberculin skin test within the prior 12 months would only need one Mantoux tuberculin skin test; and

xi. The only exceptions shall be patients with documented negative two-step Mantoux tuberculin skin test (less than 10 millimeters of induration or less than five millimeters of induration if immunosuppressed) within the past year. Patients with a documented positive Mantoux tuberculin skin test (10 millimeters of induration or five millimeters of induration if immunosuppressed) or employees who have received appropriate medical treatment for tuberculosis or latent tuberculosis infection.

3. The patient's history of psychological or psychiatric problems and treatment, which shall include a determination of the patient's current psychological status;

4. A mental status assessment on all patients and a psychiatric assessment, when clinically indicated;

5. The patient's family and relationships, including relationships evidencing co-dependency, the patient's current living situation, and any legal proceedings involving the patient, for purposes of social assessment;

6. The patient's interests and physical abilities and limitations, for purposes of recreational assessment; and

7. For purposes of vocational and educational assessment, the patient's:

i. Current work skills, employment status and potential for improving those skills or developing new ones;

ii. Educational background;

iii. Aptitudes, interests and motivation;

iv. Physical abilities and any handicaps or disabilities;

v. Relationships with co-workers and supervisors; and

vi. Current and prior work-related problems, including those related to substance abuse and dependence.

(c) On admission, patients identified with latent tuberculosis infection (Mantoux tuberculin skin test five millimeters or more of induration if immunosuppressed and 10 millimeters or more for all others) shall have a chest x-ray and medical evaluation.

1. Patients whose chest x-rays are not compatible with tuberculosis are highly recommended for treatment for their latent infection. If prescribed, such therapy shall be made available by the facility.

2. Patients whose chest x-rays are compatible with tuberculosis shall be isolated and subsequently transferred to a facility with a tuberculosis isolation room and shall not return to the residential substance abuse facility until medically cleared by a physician.

3. Reserved.

4. Reserved.

**8:42A-9.2 Patient treatment planning**

(a) The facility shall establish a patient treatment plan for every patient which shall be developed from the assessments made of the patient in accordance with N.J.A.C. 8:42A-9.1.

1. The facility shall initiate development of the treatment plan upon the patient's admission, and shall commit the patient's treatment plan to the patient record within seven days following the patient's admission.

2. The facility shall address each problem identified in the patient assessment within the patient treatment plan, and shall include at least the following:

i. Orders for treatment or services, medications and diet;

ii. The patient's personal goals;

iii. The specific goals of treatment or services;

iv. The time intervals for review of the patient's response to treatment or services;

v. Time frames for the accomplishment of the goals;

vi. The assessment measures for determining the effectiveness of treatment or services;

vii. Discharge plans; and

viii. The individual(s) responsible for implementation of the treatment plan.

(b) Practitioners in each of the services providing care to a patient shall participate in the development of the patient treatment plan relative to the services the practitioner shall provide.

(c) The patient and the patient's family, if indicated, shall participate in the development of the patient treatment plan, including the discharge plan, which shall be documented in the patient's clinical record by the facility.

1. If a physician documents in the patient's clinical record that the patient's participation in the development of the patient treatment plan is medically indicated, a member of the multidisciplinary team providing services to the patient shall review the patient treatment plan with the patient prior to implementation, the family shall be informed of the treatment plan, and the facility shall document these activities in the patient's clinical record.

(d) The multidisciplinary team shall review the patient treatment plan at least every 30 days, with such review, and revisions, if any, documented in the patient's clinical record.

1. The multidisciplinary team shall revise the patient treatment plan based upon the patient's response to the care provided and upon the patient's abilities and disabilities.

(e) In addition to (d) above, each member of the multidisciplinary team shall assess and reassess the effectiveness of services rendered as services are rendered, based on criteria for evaluation as set forth in the patient treatment plan, and shall record the assessments in the patient's clinical record.

(f) Self-help group meetings shall be held onsite or transportation provided to offsite meetings throughout the treatment stay to facilitate patient involvement in such groups upon discharge from the facility.

(g) Facilities providing treatment services for both juveniles and adults shall maintain separate treatment programs for juveniles.

## SUBCHAPTER 10. SUBSTANCE ABUSE COUNSELING SERVICES AND SUPPORTIVE SERVICES

### 8:42A-10.1 Provision of substance abuse counseling

(a) Every residential substance abuse treatment facility shall provide substance abuse counseling on-site, and shall assign every patient to a substance abuse counselor.

(b) A facility shall maintain a ratio of substance abuse counselors to patients on the basis of each facility's daily census, with substance abuse counseling required as follows:

1. For hospital and non-hospital based (medical) detoxification facilities, one substance abuse counselor for every 20 patients, to provide a minimum of two one hour counseling sessions per detoxification episode;

2. For short-term residential facilities, one substance abuse counselor for every eight patients, with each patient receiving at least 12 hours of counseling per week, on at least six separate occasions and shall include a minimum of one hour of individual patient counseling;

3. For long-term residential facilities including therapeutic communities, one substance abuse counselor for every 12 patients, with each patient receiving at least eight hours of counseling per week (on at least five separate occasions per patient) with at least one hour of individual patient counseling per week;

4. For extended care facilities, one substance abuse counselor for every 15 patients, with each patient receiving six hours of counseling per week (on at least three separate occasions per patient) with at least one hour of individual patient counseling per week;

5. For halfway houses, one substance abuse counselor for every 20 patients, with each patient receiving at least five hours of counseling per week, with at least one hour of individual patient counseling; and

6. Group counseling sessions for short-term residential facilities shall have, at a minimum, one counselor for eight or fewer patients, group counseling sessions for long-term residential facilities including therapeutic communities, extended care facilities and halfway houses shall have at a minimum, one counselor for 12 or fewer patients.

(c) Every facility shall provide each patient a minimum number of didactic sessions each week with respect to at least drug, alcohol, and tobacco education, AIDS education and health education, subject to the following:

1. For hospital and non-hospital based (medical) detoxification facilities, at least two hours per detoxification episode:

2. For short-term residential facilities, at least eight hours per week;

3. For long-term residential facilities including therapeutic communities and extended care facilities, at least three hours per week; and

4. For halfway houses, at least one hour per week;

(d) Each facility shall provide family counseling, including counseling of a patient's family members who exhibit co-dependent behavior.

(e) A facility providing medically monitored detoxification services shall provide substance abuse counseling as ordered by a physician, in accordance with the physician's specifications in the patient's clinical record.

(f) Each facility shall provide patients and their family members information regarding the desirability of participating in self-help and support groups, shall make literature and representatives of such groups available to patients and their families, and enable patients and their families to attend some meetings of support groups.

(g) Each substance abuse facility shall design programs to assure that patients spend at least seven hours each day in structured activities.

**8:42A-10.2 Director of substance abuse counseling services**

(a) Every facility shall appoint a director of substance abuse counseling service.

(b) The director of substance abuse counseling services shall be responsible for the direction, provision and quality of substance abuse counseling services, and in so doing shall be responsible for the following:

1. Developing and maintaining written objectives, policies and procedures, an organizational plan and a quality assurance program for the substance abuse counseling services;

2. Participating in planning and budgeting for the substance abuse counseling services;

3. Ensuring that substance abuse counseling services are provided as specified in the patient treatment plan, and coordinated with other patient care services in order to provide a continuum of care for the patient;

4. Assisting in developing and maintaining written job descriptions for substance abuse counseling personnel, and assigning duties; and

5. Participating in staff education activities and providing consultation to facility personnel.

**8:42A-10.3 Responsibilities of substance abuse counselors**

(a) Each substance abuse counselor shall be responsible for, with respect to assigned patients:

1. Assessing the counseling needs of the patient;

2. Preparing the substance abuse counseling portion of the patient treatment plan;

3. Providing the substance abuse counseling services specified in the patient treatment plan;

4. Reassessment of the patient;

5. Revision of the substance abuse counseling portion of the patient treatment plan;

6. The development of the patient discharge plan;

7. Participating fully as a member of a multidisciplinary team for assigned patients; and

8. Documenting services, assessments and reassessments in the patient's clinical record.

**8:42A-10.4 Supportive services**

(a) Every facility shall provide or coordinate the following services for each patient as appropriate to the patient's treatment plan:

1. Vocational and educational counseling; and

2. Legal services rendered by an attorney licensed or otherwise authorized to practice law in this State, when such services are related to the patient's treatment.

(b) Every facility shall provide support services in accordance with its patient care policies governing financial arrangements established pursuant to N.J.A.C. 8:42A-6.2.

(c) Individuals responsible for providing or coordinating the provision of support services for a patient shall record the services provided in the patient's clinical record.

## SUBCHAPTER 11. EDUCATIONAL SERVICES

### 8:42A-11.1 Provision of education services

(a) Every residential substance abuse treatment facility shall provide, or coordinate the provision of, educational services for patients, as specified in the patient's treatment record.

1. Educational services may be provided in a public or private educational institution in the community, in an approved on-site school operated by the facility, or on-site pursuant to an agreement with and under the direction of the staff of a nearby school district based on a home instruction model.

2. Regardless of the method by which the educational services are delivered to patients, substance abuse counselors shall periodically confer with teachers and/or principals on the progress of each patient.

3. Whenever appropriate, the substance abuse facility shall encourage patients to become active in extracurricular school activities, and shall make arrangements necessary to enable the patient to participate.

(b) The facility shall ensure that any juvenile who legally is not attending school participates in a training program that provides necessary life skills, vocational training, and teaches methods of job acquisition.

(c) The substance abuse facility shall provide community vocational education services that are appropriate to the age, skill level, interest and abilities of those juvenile patients for whom such services are required on-site.

(d) Facilities providing services to women and children shall develop and implement policies and procedures to insure that mothers engage in at least 45 minutes each day of age appropriate activities with their children. These activities should include the following: language activities, for example, picture books; sensory activities, for example, teething toys; manipulative activities, for example, puzzle blocks; building activities, for example, soft lightweight blocks; large muscle activities, for example, riding or rocking toys; and activities involving music, arts, science and math.

### 8:42A-11.2 Administrator's responsibilities

(a) The administrator of the facility or the administrator's designee shall be responsible for the direction, provision and quality of the educational services, and, in so doing, shall be responsible for the following:

1. Developing and implementing written objectives, policies, and procedures, an organizational plan and a quality assurance plan for the educational service;

2. Ensuring that educational services are provided to each patient as specified in the patient treatment plan, and coordinated with other patient care services to provide a continuum of care for the patient, with educational services documented in the patient record; and

3. Assisting in development of written job descriptions for education service personnel, and assigning duties to such personnel.

## SUBCHAPTER 12. LABORATORY AND RADIOLOGICAL SERVICES

### 8:42A-12.1 Provision of laboratory and radiological services

(a) The residential substance abuse treatment facility shall provide laboratory and radiological services directly in the facility or shall assure the availability of services through written affiliation agreements.

1. The facility shall contract only with laboratories which are licensed or approved by the Department, in accordance with N.J.A.C. 8:44 and 8:45.

2. The facility shall contract only with radiological services which are registered by the New Jersey Department of Environmental Protection, Bureau of Radiological Health, in accordance with N.J.A.C. 7:28.

(b) The facility shall establish and implement policies and procedures for obtaining, identifying, storing and transporting laboratory specimens.

## SUBCHAPTER 13. RECREATIONAL SERVICES

### 8:42A-13.1 Provision of recreational services

(a) Every residential substance abuse treatment facility shall provide a planned, diversified program of recreational activities that allows patients to participate on an individual or group basis in physical, social, intellectual, religious and cultural activities both indoor and outdoor.

(b) The facility administrator or the administrator's designee shall be responsible for the direction, provision and quality of the recreational service, and in so doing shall be responsible for at least the following:

1. Development and implementation of written objectives, policies and procedures, an organizational plan, and a quality assurance program for the recreational service;

2. Ensuring that recreational services are provided for each patient as specified in the patient treatment plan, and coordinated with other patient care services to provide a continuum of care for the patient, with documentation of services provided in the patient's clinical record;

3. Assisting in the development of written job descriptions for recreational service personnel, and assigning duties to such personnel;

4. Posting a current weekly recreational activities schedule where it can be read by patients and staff; and

5. In facilities serving women and children, the provision of age appropriate recreational activities for the children while the mothers are participating in treatment services as well as the provision of recreational activities for mothers and their children.

## SUBCHAPTER 14. PHARMACEUTICAL SERVICES

### 8:42A-14.1 Provision of pharmaceutical services

(a) Residential substance abuse treatment facilities shall make pharmaceutical services available to patients 24 hours a day, seven days a week, directly or through written affiliation agreements.

1. If the facility has an institutional pharmacy, the pharmacy shall comply with all laws applicable to any pharmacy operated in this State, including N.J.A.C. 13:39, State Board of Pharmacy Rules, and current registration with the Federal Drug Enforcement Administration and the Department in accordance with N.J.S.A. 24:21-1 et seq. (New Jersey Controlled Dangerous Substance Act).

(b) If the facility has an institutional pharmacy, it shall establish a multidisciplinary Pharmacy and Therapeutics Committee responsible for at least the following:

1. Development of policies and procedures regarding: evaluation, selection, obtaining, dispensing, storage, distribution, administration, use, control, accountability, and safe handling practices pertaining to all medications used in the treatment of patients, subject to documented review of the facility's governing committee;

2. Development of a formulary, and review thereof on at least an annual basis; and

3. Review of medication errors and adverse medication or treatment reactions, and provision of recommendations for corrective action, as appropriate, as part of the facility's quality assurance program.

(c) If the facility coordinates pharmaceutical services through a written affiliation agreement, the duties of the Pharmacy and Therapeutics Committee may be assumed by the patient care policy committee, so long as the assumption of the responsibilities set forth in this subchapter are clearly delegated in the plan of operation or bylaws of the facility to the patient care policy committee.

1. One requirement of a written affiliation agreement shall include the services of a pharmacist as a consultant for establishing policies and procedures and for a general review on a quarterly basis.

### 8:42A-14.2 Standards for drug administration

(a) The facility's policies and procedures shall ensure that medication, in the correct strengths and dosages, at the correct time intervals, are administered to the correct patient through the prescribed route of administration. The facility's policies and procedures shall assure a method of tracking the line of possession of the medications while in the facility and shall describe the facility's plan to assure the adequate maintenance of supplies, including at least the following:

1. Methods for procuring medications on a routine basis, in emergencies and in the event of disaster;

2. Stocking and maintenance of emergency kits and carts; including:

i. The location and contents of kits and carts;

ii. Frequency of reviewing contents and expiration dates thereof;

iii. Assignment of responsibility for reviewing contents; and

iv. Emergency kits should have a breakable seal to indicate use since they are not to be kept under lock and key.

3. Acceptable methods for ordering medications, consistent with the following:

i. Orders shall be in writing, and shall specify the name and strength of the medication, dose, frequency and route of administration;

ii. Orders shall be signed and dated by the prescriber;

iii. Verbal orders shall be written and signed within 24 hours of the original order and provide the information required in (a)3i and ii above; and

iv. Special requirements for prescribing or dispensing controlled drugs shall be noted on the prescription and in the patient's clinical record;

4. Administration of medication, including establishment of the times for administration of medication prescribed;

5. If the facility permits it, self-administration of medication, including:

i. A prohibition on self-administration of medication except upon a written order of the prescriber;

ii. Storage and labeling of medications including directions for use and appropriate cautionary and/or warning messages;

iii. Methods for documenting self-administration of medication in the patient's clinical record;

iv. Training and education of patients in self-administration and the safe use of medications; and

v. Establishment of precautions against patients sharing their medications with one another;

6. Procedures for documenting and reporting adverse medication reactions, medication errors, and medication defects, subject to the following:

i. Allergies shall be documented in the patient's clinical record and on its outside front cover; and

ii. Medication product defects shall be reported in accordance with the United States Pharmacopoeia, USP23NF18 (1995, as amended and supplemented), published by the US Pharmacopeia Convention, 12601 Twinbrook Parkway, Rockville, MD 20852, incorporated herein by reference.

7. Procedures for ensuring the immediate delivery of STAT doses;

8. If the facility permits it, use of over the counter floor stock medications approved as set forth on a list maintained at the facility, and the amounts that may be and are stored throughout the facility;

9. Discontinuation of medication orders, including:

   i. The length of time medication orders may be in effect, for medications that are not specifically limited as to duration of use or number of doses when ordered, including intravenous infusion solutions; and

   ii. A process for notifying the prescriber prior to the expiration of a medication order in accordance with the written policy of the facility, to ensure that the medication for the specific patient is discontinued if no specific renewal is ordered;

10. Standards for the purchase, storage, safeguarding, accountability, use and disposal of medications consistent with N.J.A.C. 13:39 and N.J.S.A. 24:21-1 et seq.;

11. Standards for the procurement, storage, use and disposal of needles and syringes in accordance with the laws of this State, and a system of accountability therefore which shall not require counting of individual needles and syringes after they are placed in a container for disposal;

12. Standards for the control of medications subject to N.J.S.A. 24:21-1 et seq., consistent with of N.J.A.C. 13:39 and other applicable Federal and State laws, including:

   i. Provisions for a verifiable record system for controlled medication;

   ii. Procedures to be followed when inventories of controlled medications cannot be verified, medications are lost, contaminated, unintentionally wasted or destroyed, which shall include a written report of the incident signed by the individuals involved and any witnesses; and

   iii. Procedures for the intentional wasting of controlled medications, including the disposal of partial doses, which shall include written documentation of the event signed by the individual responsible for the intentional wasting of the medication and an individual assigned to witness the event;

13. Maintenance of a record of each prescriber's Federal Drug Enforcement Administration numbers for this State;

14. Data to be maintained on each nursing unit, including:

   i. A list of abbreviations, metric conversion charts and chemical symbols, subject to approval by the medication staff;

   ii. Specific information on medications and other drugs, including indications, contraindications, actions, reactions, interactions, cautions, precautions that should be taken, toxicity, and dosages that is, Physician's Desk Reference (PDR), United States Pharmacopeia (USP); and

   iii. Antidote information and the telephone number of the State Poison Information and Education System center 1-800-POISON-1.

15. The pharmaceutical service shall have all current Federal and State laws information available on site; and

16. In no instance shall the facility permit drug or medication samples to be accepted, stocked, distributed or otherwise used for any patient or staff at the facility unless specifically approved by the Pharmacy and Therapeutics Committee in writing.

    i. If the facility utilizes drugs marked "samples," the Pharmacy and Therapeutics Committee shall develop a mechanism for the control and limitations of these drugs in accordance with N.J.A.C. 13:35-6.6.

**8:42A-14.3 Standards for storage of medications**

(a) The facility shall keep all medications and intravenous solutions in locked storage areas, stored in accordance with manufacturer's instructions at or near the nursing unit(s).

1. The facility shall store all medications that require refrigeration in a locked box within a refrigerator, in the locked medication room, at temperatures that conform with United States Pharmacopoeia requirements of 36 to 46 degrees Fahrenheit.

2. The facility shall store all scheduled medications separate from non-scheduled medication unless unit dose.

3. The facility shall keep all medications for external use separate from medications for internal use.

(b) The facility shall keep all medication storage and preparation areas locked when not in use.

**8:42A-14.4 Additional standards for facilities that provide medically monitored detoxification services.**

(a) Any facility which provides medically monitored detoxification services shall require the pharmacist(s) to inspect all areas of the facility where medications are dispensed, administered, or stored on a quarterly basis. There shall be an inspection policy and procedure which requires the pharmacist(s) to maintain a written record of each inspection.

(b) Each facility providing detoxification services shall appoint a pharmacist as the director of pharmaceutical services or a consulting pharmacist to direct, provide and monitor the quality of pharmaceutical services, and, in so doing, be responsible for at least the following:

1. Working with the Pharmacy and Therapeutics Committee or patient care policy committee, as appropriate, in developing policies and procedures for the delivery of quality pharmaceutical services to patients of the facility;

2. Participating in the planning and budgeting for pharmacy services;

3. Coordinating and integrating pharmacy services with other patient care services to provide a continuum of care;

4. Assisting in the development of job descriptions and assignment of duties to pharmacy personnel, if any;

5. Working with the multidisclipinary team in achieving its goals and duties;

6. Maintaining a record system that identifies the signatures of all authorized prescribers;

7. Maintaining all records of all pharmaceutical services transactions, including a record system for requisition and distribution of pharmaceutical supplies throughout the residential facility;

8. Establishing standards to assure compliance with (c) and (d) below; and

9. Conducting a drug regimen review on a schedule developed by the Pharmacy and Therapeutics Committee.

(c) Every facility which provides detoxification services shall have a unit dose medication distribution system by November 15, 2002, which complies with the following:

1. Each patient shall have a separate receptacle labeled with his or her first and last name and room number that contains his or her own medications.

2. Each medication shall be individually wrapped and labeled with its generic name, trade name (if appropriate), strength, lot number or reference code, expiration date, manufacturer's or distributor's name, and ready for administration to the patient.

i. If the facility repackages medications in single unit packages, the facility shall establish written standards for labeling packages to assure identification of the lot number or reference code and the manufacturer's or distributor's name in accordance with the United States Pharmacopeia (USP) or generally accepted pharmacy practices.

ii. Each facility which provides detoxification services shall have written standards specifying medications it shall not obtain in single unit packages, and which it shall not repackage as single units at the facility. The Pharmacy and Therapeutics Committee shall be responsible for making these determinations.

3. Any facility which provides detoxification services shall establish a policy for exchange of patient medications no less frequently than every three days, with the number of doses during each exchange for each patient sufficient for no more than 72 hours. The Pharmacy and Therapeutics Committee shall establish and enforce procedures to insure the accountability for all medications used in the facility.

4. Any facility which provides detoxification services shall establish a process for providing personnel responsible for the administration of the medications with cautionary instructions and additional information as applicable to the medications to be administered.

(d) Any facility which provides detoxification services shall establish and utilize an intravenous infusion admixture service operated by the pharmaceutical service by November 15, 2002 with standards consistent with the following:

1. Appropriate safety measures shall be established for the preparation, sterilization and admixtures of intravenous infusions solutions in both medication preparation areas and patient care areas.

i. Admixtures of intravenous infusion solutions shall be prepared under a laminar airflow hood.

ii. Appropriate quality control standards for laminar hoods shall be established and shall include cleaning, microbiological monitoring as stringent as the infection prevention control standards of the facility generally, with review or operational efficiency documented at least every 12 months or as required by the manufacturer, whichever is sooner.

iii. Labeling criteria which require that a supplementary label be affixed to any container of intravenous infusion solution to which medications are added, specifying at least:

(1) The patient's first and last name and room number;

(2) The name of the solution;

(3) The date, time and rate of administration;

(4) The name and amount of the medication(s);

(5) The date and time of the addition of the medication(s);

(6) Identification of the pharmacy personnel who prepared the admixture;

(7) Identification of the pharmacist who prepared or supervised preparation of the admixture;

(8) Additional instructions for the admixture, including storage requirements; and

(9) The expiration date of the admixture solution.

## SUBCHAPTER 15. DIETARY SERVICES

### 8:42A-15.1 Provision of dietary services

(a) Every residential substance abuse treatment facility shall provide dietary services to meet the nutritional needs of its patients.

1. To the extent practicable, the facility shall provide special dietary services to meet the health or medical needs or religious or cultural beliefs of patients.

(b) Every facility shall engage the services of a dietician to be responsible for the direction, provision and quality of the dietary services.

1. If the dietician is engaged on a consulting basis, the facility shall require the dietician to make on-site visits periodically at hours that vary on successive visits, so that the dietician is on-site at different times of the day when dietary services are required to be provided to patients.

2. The dietician shall engage in at least the following:

i. Developing and implementing written objectives, policies, a procedure manual, an organizational plan, and a quality assurance program for the dietary service;

ii. Participating in planning and budgeting for the dietary service;

iii. Ensuring that dietary services are provided as specified in the dietary portion of the patient treatment plan and are coordinated with other patient care services to provide a continuum of care for the patient;

iv. Assisting in developing and maintaining written job descriptions for dietary personnel, and assigning duties based upon education, training, competencies, and job descriptions; and

v. Participating in staff education activities and providing consultation to facility personnel.

(c) Every facility shall appoint a full-time food service supervisor who shall function under the direction of the dietician.

(d) Every facility shall require and ensure that either a dietician or a food service supervisor shall be on duty seven days a week.

### 8:42A-15.2 Responsibilities of dietary personnel

(a) Dietary personnel shall provide the following:

1. Assessment and reassessment of the dietary needs of the patient and preparation of the dietary portion of the patient treatment plan based on the assessment;

2. Provision of dietary services to patients as specified in the dietary portion of each patient's treatment plan;

3. Participation in the multidisciplinary team in the development, implementation, revision of the patient treatment plan; and

4. Completion of clinical notes, including documentation of the required activities of (a) 1 and 2 above and progress notes.

**8:42A-15.3 Requirements for dietary services**

(a) The facility shall schedule dietary personnel to assure that dietary services are operational for a continuous period of at least 12 hours daily.

(b) The facility shall establish its dietary services in compliance with N.J.A.C. 8:24.

(c) The facility shall keep a current diet manual in the dietary service and in each nursing unit.

(d) The facility shall ensure that:

1. Menus are prepared with regard for the nutritional and therapeutic needs, cultural backgrounds, food habits, and personal food preferences of patients;

2. Written, dated menus are planned at least 14 days in advance for all diets, and that the same menu is not used more than once in one week;

3. Current menus with portion sizes and any changes in menus shall be posted in the food preparation area, and menus, including any changes shall be kept on file in the dietary service for at least 30 days;

4. Diets served shall be consistent with the diet manual and in accordance with physicians' orders;

5. Food shall be prepared by cutting, chopping, grinding, or blending to meet the needs of each patient.

6. At least three meals or their equivalent shall be prepared and served daily to patients.

i. At least two meals shall contain three or more menu items, one of which shall be or shall include a high quality protein food such as meat, fish, eggs, or cheese.

ii. Each meal shall represent no less than 20 percent of the day's total calories.

iii. At least 10 percent of the day's total calories shall be provided by protein.

7. Nutrients and calories shall be provided for each patient, as ordered by a physician, based upon the current recommended dietary reference intakes of the Food and Nutrition Board, Institute of Medicine, National Academy of Sciences, 2101 Constitution Ave., Washington, DC 20148, adjusted for age, sex, weight, physical activity, and therapeutic needs of the patient;

8. Between-meal nourishments shall be provided and beverages shall be available at all times for each patient, unless medically contraindicated as documented by a physician in the patient's clinical record;

9. Substitute foods and beverages of equivalent nutritional value shall be available to all patients; and

10. No more than 14 hours shall elapse between an evening meal and breakfast the next morning.

## SUBCHAPTER 16. EMERGENCY SERVICES AND PROCEDURES

### 8:42A-16.1 Emergency plans and procedures

(a) The residential substance abuse treatment facility shall maintain written emergency plans, policies, and procedures to be followed in case of hazards that necessitate an evacuation, including internal and external disasters such as fire, natural disaster, bomb threats, or industrial or radiological accidents, ensuring that patients receive necessary services during the evacuation or other emergency.

(b) The facility shall conspicuously post throughout the physical plant a written evacuation diagram that includes evacuation procedures and location of fire exits, alarm boxes, and fire extinguishers.

(c) The facility shall provide training for all employees in procedures to be followed in the event of a fire including use of fire-fighting equipment and patient evacuation as part of their initial orientation and at least annually thereafter.

### 8:42A-16.2 Drills, tests, and inspections

(a) The facility shall conduct drills of emergency plans on each shift at least quarterly.

1. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge.

2. The drills on each shift shall include at least one drill for emergencies due to fire and one drill for emergencies due to disasters other than fire, such as storm, flood, other natural disaster, bomb threat, or radiological accident.

(b) The facility shall perform quarterly tests of the building's manual pull alarm system and shall maintain documentation of test dates, locations of manual pull alarms tested, persons testing the alarms, and results of the tests.

(c) The facility shall examine its fire extinguishers annually and maintain or replace them in accordance with manufacturer's requirements, National Fire Protection Association (N.F.P.A.) 10, 1996-1997, as amended and supplemented, incorporated herein by reference, and N.J.S.A. 52:27D-198 and N.J.A.C. 5:70, the New Jersey Uniform Fire Code. NFPA publications are available from the NFPA, One Battery March Park, P.0. Box 9101, Quincy, MA 02269-9101.

(d) The facility shall conduct the following inspections:

1. Monthly testing of emergency lighting;

2. Monthly testing of the hot water used in the facility;

3. Semiannual inspection of the fire detection system;

4. Semiannual inspection of the automatic sprinkler system;

5. Annual fire inspection by local fire code authority;

6. Annual elevator inspection in accord with N.J.A.C. 5:23-12.3, Elevator Safety Subcode; and

7. Annual inspection of the heating and ventilation system.

(e) The facility shall document the results of all inspections, including:

1. Documentation of test date;

2. The location of the system or requirement tested;

3. The name and title of person conducting test; and

4. The result of the test.

**8:42A-16.3 Emergency medical services**

(a) The facility shall establish written policies and procedures for the provision of emergency services based on the types of patients typically treated at the facility, including policies and procedures regarding emergency kits and emergency carts, if applicable.

1. The facility shall be able to respond to medical emergencies occurring on-site during its hours of operation.

2. The facility shall make provision for emergency transportation and emergency medical services to be delivered at a hospital.

i. All agreements with hospitals should be in writing.

3. The facility shall specify the locations, contents, frequency of review and personnel assigned to review emergency kits and emergency carts, as applicable, and shall ensure that emergency kits are kept secure, but not under lock and key.

4. The facility shall require that at least one person trained in the use of the emergency equipment maintained on-site, is available whenever there is a patient on-site.

(b) The facility shall post the numbers of emergency transportation along with police, fire, ambulance (911) and the State poison control center number on each of its units.

## SUBCHAPTER 17. PATIENT RIGHTS

### 8:42A-17.1 Establishment of policies and procedures

(a) The residential substance abuse treatment facility shall establish and implement written policies and procedures regarding the rights of patients which shall be available to patients, staff, and the public and shall be conspicuously posted in the facility.

(b) The facility shall provide in-service education to its staff concerning the implementation of policies and procedures regarding patient rights annually, and as part of new employee orientation.

(c) The facility shall comply with all applicable State and Federal statutes and rules concerning patient rights.

### 8:42A-17.2 Rights of each patient

(a) Each patient receiving services in a facility shall have the following rights:

1. To be informed of these rights, as evidenced by the patient's written acknowledgment or by documentation by staff in the clinical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms the patient could understand;

2. To be notified of any rules and regulations the facility has adopted governing patient conduct in the facility;

3. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;

4. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment, to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;

5. To receive from the patient's physicians or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risks(s) of treatment, and expected result(s);

    i. If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian;

    ii. Release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's clinical record; and

    iii. All consent to release information shall be signed by the patient or the patient's parent, guardian or legally authorized representative;

6. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment;

    i. A patient's refusal of medication or treatment shall be documented in the patient's clinical record;

7. To participate in experimental research only when the patient gives informed, written consent to such participation, or when a guardian or legally authorized representative gives such consent for an incompetent patient in accordance with law, rule and regulation;

8. To voice grievances or recommended changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as group, free from restraint, interference, coercion, discrimination, or reprisal;

9. To be free from mental and physical abuse, free from exploitation, and free from use of restraints unless they are authorized by a physician for a limited period of time to protect the patient or others from injury;

    i. Drugs and other medications shall not be used for discipline of patients or for convenience of facility personnel;

10. To confidential treatment of information about the patient;

    i. Information in the patient's clinical record shall not be released to anyone outside the facility without the patient's written approval to release the information in accordance with Federal statutes and rules for the Confidentiality of Alcohol and Drug Abuse Patient Records at 42 U.S.C. 290dd-2, and 290ee-2 and 42 C.R.F. Part 2-Section 2.1 et seq., unless the release of the information is required and permitted by law, a third-party payment contract, a peer review, and the information is needed by the Department for statutorily authorized purposes;

    ii. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;

11. To be treated with courtesy, consideration, respect, and with recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy;

    i. The patient's privacy also shall be respected when personnel are discussing the patient;

12. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient and is otherwise in accordance with local, State, and Federal laws and rules;

13. To exercise civil and religious liberties, including the right to independent personal decisions.

    i. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient.

14. To not be discriminated against because of age, race, religion, sex, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights because of receipt of services from the facility;

15. To be transferred or discharged only for medical reasons, for his or her welfare or that of other patients, upon the written order of a physician, or for failure to pay required fees as agreed by the client at time of admission (except as prohibited by sources of third-party payment).

    i. Transfers and discharges, and the reasons therefore, shall be documented in the patient's clinical record, and the patient's physician and family promptly notified;

    ii. If a transfer or discharge on a non-emergency basis is requested by the residential substance abuse treatment facility, the patient and his or her family shall be given at least 10 days advance notice of such transfer or discharge, except as otherwise provided for in N.J.A.C. 8:42A-6.4(c);

16. To be notified in writing and to have the opportunity to appeal an involuntary discharge;

17. To have access to and obtain a copy of his or her clinical record, in accordance with the facility's policies and procedures and applicable Federal and State laws and rules;

18. To be assured security in retaining and using personal clothing and possessions as space permits, unless to do so would be unsafe or would infringe upon the rights of other patients.

    i. If the patient has property on deposit with the facility, he or she shall have daily access to such property during specific periods established by the facility; and

19. To be allowed visiting time at reasonable hours in accordance with the patient treatment plan and, if critically ill, to be allowed visits from his or her family or legally authorized representative at any time, unless medically contraindicated as documented by a physician in the patient's clinical record.

    i. Members of the clergy shall be notified by the facility at the patient's request and shall be admitted at the request of the patient and/or family at any time.

**8:42A-17.3 Notices for assistance**

(a) The administrator shall provide all patients and their families upon request with the names, addresses, and telephone numbers of the following offices where complaints may be lodged:

New Jersey State Department of Health and Senior Services
Division of Addiction Services
PO Box 362
Trenton, New Jersey 08625-0362
Telephone: (609) 292-5760

and

New Jersey Department of Health and Senior Services
Certificate of Need and Acute Care Licensure
PO Box 360
Trenton, New Jersey 08625-0360
Telephone: (800) 792-9770

(b) The administrator shall provide all patients and their families upon request with the names, addresses, and telephone numbers of offices where information concerning Medicaid coverage may be obtained.

(c) The administrator shall conspicuously post the addresses and telephone numbers contained in (a) and (b) above in the admissions waiting area or room, the patient service area of the business office, and other public areas throughout the facility.

## SUBCHAPTER 18. DISCHARGE PLANNING SERVICES

### 8:42A-18.1 Discharge planning

(a) The residential substance abuse treatment facility shall initiate a discharge plan for each patient upon the patient's admission.

1. The discharge plan shall be in writing and shall address all unresolved problems identified at admission or during treatment.

2. The patient and the patient's family or legally authorized representative shall participate in developing the discharge plan, and such participation shall be documented in the patient's clinical record.

(b) The facility shall establish and implement staff educational services regarding discharge planning.

### 8:42A-18.2 Discharge planning policies and procedures

(a) The facility shall establish and implement written policies and procedures for discharge planning services, which shall address at least the following:

1. The person or persons responsible for planning, providing, and/or coordinating discharge planning services, including:

i. Interviewing each patient and evaluating needs and developing goals for aftercare services for each patient;

ii. Making referrals to community agencies and resources for aftercare services not including additional residential or outpatient treatment services provided directly by the facility to provide a continuum of care for the patient;

iii. Requesting representatives of support groups, such as Alcoholics Anonymous, to accompany patients to support group meetings following discharge;

iv. Assessing the outcome of aftercare services planned for each patient; and

v. Developing and implementing a schedule of follow-up contacts after the patient's discharge;

2. The time period for completing each patient's discharge plan;

3. The time period that may elapse before a reevaluation of each patient's discharge plan is performed;

4. Use of the multidisciplinary team in discharge planning;

5. The criteria for patient discharge;

6. The methods of patient and family involvement in developing the discharge plan;

7. The criteria for termination of aftercare services; and

8. Discharge of juvenile patients only to parent(s) or legal guardian.

**8:42A-18.3 Patient and family education**

(a) The facility shall include education of the patient and his or her family or legally authorized representative as part of its discharge planning service and shall provide information regarding at least the following:

1. The symptoms, effects, and treatment of substance abuse;

2. Co-dependency and its effect on the treatment of substance abuse;

3. Implementation of self-care rehabilitation measures following discharge;

4. Community agencies and resources available for aftercare services, including outpatient substance abuse treatment services, health care facilities (including resources for prenatal care and services for the treatment of Human Immunodeficiency Virus (HIV) infection), vocational rehabilitation centers, legal and social agencies, and rehabilitation programs; and

5. The availability of support groups, and referrals when appropriate, to programs, including, but not limited to, Narcotics Anonymous, Nar-Anon, Alcoholics Anonymous, Al-Anon, Alateen, and for the Women, Infant and Children (WIC) Program.

## SUBCHAPTER 19. CLINICAL RECORDS

### 8:42A-19.1 Maintenance of clinical records

(a) The residential substance abuse treatment facility shall establish and implement policies and procedures for production, maintenance and retention of clinical records, which shall be reviewed at least annually, by the Director and address the written objectives, organizational plan and quality assurance program for all clinical records, subject to the following:

1. The facility shall establish a clinical record for each patient.

2. The facility shall require that documentation of all services provided and transactions regarding the patient are entered in the patient's clinical record.

3. The facility shall maintain all clinical records and components thereof on-site at all times unless:

   i. Removed in accordance with a court order or subpoena;

   ii. Removed due to a physical plant emergency or natural disaster; or

   iii. Off-site storage is approved by the Department pursuant to N.J.A.C. 8:42A-19.6.

4. The facility shall preserve the confidentiality of information contained in the clinical record in accordance with Federal statutes and rules for the Confidentiality of Alcohol and Drug Abuse Patient Records at 42 U.S.C. 290dd-2 and 290ee-2 and 42 C.F.R. Part 2, Section 2.1 et seq.

(b) The facility shall establish a record system so that each patient's complete clinical record is filed as one unit within 30 days of discharge, with access to and identification of all patient clinical records maintained.

(c) The facility shall establish policies and procedures to protect clinical records against loss, tampering, alteration, destruction, unauthorized use or other release of information without the patient's consent.

(d) The facility's policies and procedures shall specify the period of time, not to exceed 30 days, within which the clinical record shall be completed following patient treatment or discharge.

(e) The facility shall establish policies and procedures regarding the transfer of the patient's clinical record information to another health care facility or an outpatient unit within the residential substance treatment facility to ensure continuity of care to the patient and patient confidentiality.

(f) The facility shall establish policies and procedures to provide copies of a patient's clinical record to the patient, the patient's legally authorized representative or a third-party payor where permitted by law or otherwise authorized in writing by the patient, consistent with N.J.A.C. 8:42A-19.5.

### 8:42A-19.2 Assignment of responsibility

The facility shall designate an employee to act as the coordinator of clinical record services and one or more employees to act in the absence of the coordinator to ensure staff access to the clinical records at all times.

**8:42A-19.3 Contents of clinical records**

(a) The facility shall require, at a minimum, the following to be included in the clinical record:

1. Patient identification data, including name, date of admission, address, date of birth, race, religion (optional), sex, and the name, address, and telephone number of the person(s) to be notified in an emergency;

2. Admission, discharge and other reports required by this rule as part of the substance abuse patient management information system;

3. The patient's signed acknowledgment that he or she has been informed of, and given a copy of, patient rights;

4. A summary of the admission interview;

5. Documentation of the medical history and physical examination, signed and dated by the physician;

6. A patient treatment plan, signed and dated by the physician;

7. Clinical notes, which shall be entered on the day service is rendered;

8. Progress notes;

9. Documentation of the patient's participation in the development of his or her treatment plan, or documentation by a physician that the patient's participation is medically contraindicated;

10. A record of medications administered, including the name and strength of the drug, date and time of administration, dosage administered, method of administration, and signature of the person who administered the drug;

11. A record of self-administered medications, if the patient self-administers medications, in accordance with the facility's policies and procedures;

12. Documentation of allergies in the clinical record and on its outside front cover;

13. The results of laboratory, radiological, diagnostic, and/or screening tests performed;

14. Reports of accidents;

15. A record of referrals to other health care providers;

16. Summaries of consultations;

17. A record of the clothing, personal effects, valuables, funds, and other property deposited by the patient with the facility for safekeeping, signed by the patient or his or her family and substantiated by receipts given to the patient or his or her family;

18. Any signed, written informed consent forms or an explanation of why an informed consent was not obtained;

19. A record of any treatment, drug, or service offered by personnel of the facility and refused by the patient;

20. Instructions given to the patient and/or the patient's family for care following discharge;

21. The discharge plan; and

22. The discharge summary, in accordance with N.J.S.A. 26:8-5.

**8:42A-19.4 Requirements for entries**

(a) The facility shall require that all orders for patient care be prescribed in writing and signed and dated by the prescriber, in accordance with the laws of this State and that all orders, including verbal orders, be verified or countersigned in writing within 24 hours.

(b) The facility shall require that all entries in the clinical record be typewritten or written legibly in ink, dated, and signed by the person entering them, or authenticated, if a computerized clinical records system is used.

1. If computer-generated orders with a physician's electronic signature are used, the facility shall develop a procedure to assure the confidentiality of each electronic signature and to prohibit the improper or unauthorized use of any computer-generated signature.

2. If a facsimile communications system (FAX) is used, entries into the clinical record shall be in accordance with the following procedures:

i. The physician shall sign the original order, history and/or examination at an off-site location;

ii. The original shall be transmitted by FAX system to the facility for inclusion in the clinical record;

iii. The physician shall submit the original for inclusion in the clinical record within seven days, unless a plain-paper laser facsimile process was used; and

iv. The copy transmitted by FAX system shall be replaced by the original, unless a plain-paper laser facsimile process was used.

(c) The clinical record shall be completed within the time frame specified in the clinical records policies and procedures, which shall be no longer than 30 days from the last treatment or discharge.

(d) The clinical record shall be available to the facility's substance abuse practitioner involved in the patient's care at all times during the hours of operation.

**8:42A-19.5 Access to clinical records**

(a) The facility shall furnish a legible, written copy of the clinical record, or portion of the clinical record, as appropriate, for a fee based on actual costs, to a patient, the patient's legally authorized representative, or a third party payer upon written request and receipt of a properly executed release of information form, within 30 days of receipt of the written request in accordance with the following:

1. The fee for copying shall not exceed $1.00 per page for the first 100 pages, and $.25 per page thereafter, not to exceed $200.00 for the entire record;

2. In addition to per page costs, the following charges are permitted:

   i. A search fee of no more than $10.00 per patient per request; and

   ii. A postage charge of actual costs for mailing, not to exceed $5.00.

3. No charges shall be assessed other than those permitted in (a)l and 2 above.

(b) The facility shall establish a policy assuring access to copies of clinical records for patients who do not have the ability to pay notwithstanding (a) above.

(c) The facility shall establish a fee policy providing an incentive for use of abstracts or summaries of clinical records but shall not impede a patient or his or her legally authorized representative's ability to receive a full or certified copy of the clinical record.

(d) The facility shall establish a policy and procedure whereby access to a patient's clinical record is provided to the patient's legally authorized representative or the patient's physician when direct access by the patient to the clinical record is medically contraindicated as documented by a physician in the patient's clinical record.

1. The physician that has determined that access to the clinical record by the patient should be restricted, shall provide a verbal explanation of the denial to the patient or the patient's family, as appropriate.

**8:42A-19.6 Preservation, storage, and retrieval of clinical records**

(a) The facility shall preserve all clinical records in accordance with N.J.S.A. 26:8-5 et seq.

(b) If the facility plans to cease operation, it shall notify the Department in writing, at least 14 days before cessation of operation, of the location where clinical records shall be stored and of methods for their retrieval.

1. The facility shall store all clinical records on-site unless off-site storage is approved by the Department.

2. The Department shall approve off-site storage if the notice from the facility requesting approval ensures that off-site storage shall maintain:

   i. Retrieval and delivery of clinical records within one business day following request, seven days per week, 24 hours per day; and

   ii. Immediate availability of clinical record information through telephone and facsimile communications systems.

## SUBCHAPTER 20. INFECTION PREVENTION AND CONTROL

### 8:42A-20.1 Infection prevention and control

(a) The administrator shall ensure the development and implementation of an infection prevention and control program.

(b) The residential substance abuse treatment facility shall establish an infection control committee composed at least of the medical director, a representative of administration and a representative from nursing services, and a person with a health care background designated by the administrator to be responsible for implementing the policies and procedures regarding infection prevention and control in the facility.

(c) The infection control committee, in consultation with each service in the facility, shall develop, implement, annually review and revise as necessary written policies and procedures regarding infection prevention and control, addressing at least the following:

1. The system within the facility for investigating, reporting, and evaluating the occurrence of all infections or diseases which are reportable in accordance with N.J.A.C. 8:57, Communicable Diseases, or are conditions that may be related to activities and procedures of the facility;

2. The system within the facility for identifying and monitoring nosocomial infections in accordance with "CDC Definition for Nosocomial Infections, 1988" incorporated herein by reference and available from the National Technical Service, United States Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161, or the Superintendent of Documents, United States Government Printing Office, Washington, DC 20402 (order number PB 88-187117);

3. The facilities infection and control practices shall be in compliance with the CDC guidelines for Prevention of Nosocomial Infections and standard precautions contained therein (see (c)2 above), and with the Occupational Safety and Health Administration rules at 29 C.F.R. 1910.1030 (Occupational Exposure to Blood Borne Pathogens), incorporated-herein by reference, and issued under 29 U.S.C. 653;

4. The control measures or studies to be initiated by the facility following identification of an infection control problem;

5. The facility's aseptic techniques, procedures to ensure employee health in accordance with N.J.A.C. 8:42A-3.7, and staff training;

6. Care of patients with communicable diseases;

7. Exclusion of personnel with communicable diseases from work, and authorization to return to work;

8. The facility's surveillance techniques to minimize sources and transmission of infection;

9. The facility's sterilization, disinfection and cleaning practices and techniques, consistent with N.J.A.C. 8:42A-20.2, including:

   i. Care of utensils, instruments, solutions, dressings, articles and surfaces; and

ii. Section, storage use and disposal of single use and other patient care items; and

10. The facility's practices regarding collection, handling, storage, decontamination, disinfection, sterilization and disposal of regulated medical waste and all other solid and liquid waste.

**8:42A-20.2 Use and sterilization of patient care items**

(a) The facility shall sterilize all instruments or medical devices that are:

1. Introduced directly into the bloodstream.

2. Introduced into areas of the body that are normally sterile or made sterile prior to introduction of the instrument or medical device; or

3. In contact or likely to come into contact with mucous membranes.

i. In lieu of sterilization, the facility may elect to disinfect the instruments or medical devices using high-level disinfection procedures.

(b) The facility shall package and label sterilized material so as to maintain sterility and permit identification of expiration dates.

1. The facility shall mark sterilized material with an expiration date, not to exceed any time frame specified by the manufacturer, if any, after which the material shall not be used.

(c) Whether sterilized or disinfected, the facility shall process all hinged instruments in an open position.

(d) The facility shall not reuse single use patient care items, and shall reprocess and reuse other patient care items in accordance with manufacturers' recommendations.

**8:42A-20.3 Care and maintenance of sterilizers**

(a) The facility shall keep all sterilizers clean by, a minimum, the following:

1. Flushing sterilizer drains at least weekly, unless otherwise specified by the manufacturer;

2. Performing biological monitoring with live spores on each ethylene oxide sterilizer no less than daily, and following any repair of the sterilizer; and

3. Performing biological monitoring with live spores on each steam sterilizer used to sterilize instruments no less than weekly, and following any repair of the sterilizer.

(b) The facility shall record the following:

1. Each sterilization load, including the date, load number, and contents of the load.

i. This record shall be maintained at least 12 months from the date of recording;

2. At the completion of each sterilization load, the time, temperature and pressure reading on the sterilizer; and

3. The date and time of all sterilizers drain flushings.

**8:42A-20.4 Regulated medical waste**

The facility shall comply with N.J.S.A. 13:IE-48.1 et seq. (Comprehensive Regulated Medical Waste Management Act), and rules promulgated pursuant thereto, and all other applicable Federal, State and local laws that may apply to the collection, storage, handling and disposal of regulated medical waste, including, but not limited to, N.J.A.C. 7:26-3A.

**8:42A-20.5 Disposal of tissue**

The facility shall, with respect to all tissue removed surgically or by any other procedure in accordance with N.J.A.C. 13:35-4.2, incinerate or inter such tissue in accordance with N.J.S.A. 26:6.1 et seq., or otherwise dispose of such tissue by alternative, technological process approved on a case by case basis by the Department, in consultation with the New Jersey Department of Environmental Protection.

## SUBCHAPTER 21. HOUSEKEEPING, SANITATION AND SAFETY

### 8:42A-21.1 Provision of services

(a) The residential substance abuse treatment facility shall provide and maintain a sanitary and safe environment for patients.

(b) The facility shall provide housekeeping, laundry, and pest control services.

(c) The facility shall perform a documented review of housekeeping, sanitation, and safety services at least annually.

### 8:42A-21.2 Housekeeping

(a) The facility shall establish and implement a written work plan for housekeeping operations with categorization of cleaning assignments as daily, weekly, monthly, or annually within each area of the facility.

(b) The facility shall ensure that all housekeeping personnel are trained in cleaning procedures, including the use, cleaning, and care of equipment.

### 8:42A-21.3 Patient care environment

(a) The facility shall meet the following housekeeping and sanitation conditions:

1. The facility and its contents shall be clean to sight and touch and free of dirt and debris.

2. All rooms shall be free of condensation, mold growth, and noxious odors.

3. All equipment and materials necessary for cleaning, disinfecting, and sterilizing, (if applicable) shall be available in the facility at all times.

4. Thermometers which are accurate to within three degrees Fahrenheit shall be kept in a visible location in refrigerators, freezers, and storerooms used for perishable and other items subject to deterioration.

5. Articles in storage shall be elevated from the floor and away from walls, ceilings, and air vents.

6. Unobstructed aisles in storage areas.

7. Controls safe for patients, staff and pets, if any, shall be used to minimize and eliminate the presence of rodents, flies, roaches and other vermin in the facility, and to prevent the breeding, harborage, or feeding of vermin.

   i. All openings to the outer air shall be effectively protected against the entrance of insects.

8. Toilet tissue, soap, and disposable towels or air driers shall be provided in each bathroom at all times with soap and disposable towels or air driers provided at each hand washing sink.

9. Draperies, upholstery, and other fabrics or decorations shall be fire-resistant and flameproof.

10. Latex foam pillows shall be prohibited.

11. Equipment requiring drainage shall be drained to a sanitary connection, in accordance with State and local codes.

12. The temperature within patient areas of the facility shall be maintained at a minimum of 72 degrees Fahrenheit, and shall not exceed 82 degrees Fahrenheit.

    i. The facility shall maintain adequate ventilation in all areas used by patients.

    ii. The facility shall establish a written heat emergency action plan to be implemented whenever the indoor air temperature is 82 degrees Fahrenheit or higher for four consecutive hours.

13. Facilities serving women with their children on the premises shall insure that children are not exposed to lead based paint hazards in accordance with the provisions of N.J.A.C. 8:51, Childhood Lead Poisoning. Facilities constructed prior to 1978 shall be considered to contain lead based paint unless an inspection and testing by an individual with a New Jersey Lead Inspector/Risk Assessor permit has determined that the paint does not contain lead.

(b) The facility shall meet the following safety conditions:

1. Nonskid wax shall be used on all waxed floors.

2. Throw rugs or scatter rugs shall not be used.

3. All equipment shall have unobstructed space provided for operation.

4. Pesticides shall be applied in accordance with State Pesticide Control Code, N.J.A.C. 7:30.

5. All household and cleaning products in the facility shall be identified, labeled, and securely stored in a cabinet, closet, or room which is inaccessible to patients.

6. Combustible materials shall not be stored in heater rooms or within 18 feet of any heater located in an open basement.

7. Paints, varnishes, lacquers, thinners, and all other flammable materials shall be stored outside buildings in which patients are housed or otherwise have general access to, except that minimum supplies may be kept in such buildings in a locked storage room or in closets, locked metal cabinets or containers in a nonpatient area of the facility.

8. All furnishings shall be clean and in good repair, and mechanical equipment shall be in good working order.

    i. Equipment shall be kept covered to protect from contamination and accessible for cleaning and inspection.

    ii. Broken or worn items shall be repaired, replaced, or removed promptly.

9. In facilities serving women and children all areas accessible to the children shall be maintained in a safe and sanitary manner by ensuring that:

i. There are no poisonous plants;

ii. Toxic chemicals including cleaning agents are stored in locked cabinets or enclosed in areas not accessible to the children;

iii. All electrical outlets have protective covers;

iv. All fluorescent tubes and incandescent light bulbs have protective covers or shields;

v. All windows and other glass surfaces that are not made of safety glass and that are located within three feet above the floor shall have protective guards;

vi. Non-permanent safety barriers (safety gates) are installed to prevent infants from falling if the facility has stairs, ramps, balconies, porches, or elevated play areas;

vii. Materials and furniture for indoor and outdoor use are of sturdy and safe construction, easy to clean and free of hazards;

viii. Children are kept away from hot stoves, irons and ironing boards, knives, glassware and other equipment that may cause injury;

ix. Poisons, insect traps, and rodent traps are kept out of reach; and

x. All outdoor areas are maintained in a safe and sanitary manner.

**8:42A-21.4 Waste removal**

(a) The facility shall collect, store and dispose of all solid or liquid waste (which is not regulated medical waste), garbage, and trash in accordance with all applicable State and local laws and, in addition, the facility shall:

1. Store solid waste in insect-proof, rodent-proof, fire-proof, nonabsorbent and water tight containers with tight fitting covers;

2. Collect solid waste from storage areas regularly to prevent nuisances such as odors; and

3. Provide for regular, scheduled cleaning of storage areas and containers for all waste in accordance with N.J.A.C. 8:24.

(b) If garbage compactors are used, the facility shall install and use them in compliance with all State and local codes.

**8:42A-21.5 Water supply**

(a) The facility shall use a water supply for drinking or culinary purposes that is adequate in quantity, of a safe and sanitary quality, and from a water system constructed, protected, operated, and maintained in conformance with the New Jersey Safe Drinking Water Act, N.J.S.A. 58:12A-1 et seq., N.J.A.C. 7:10, and local laws, ordinances, and regulations, with no back siphonage conditions present.

(b) The facility shall maintain the temperature of the hot water used for hand washing between 95 degrees and 120 degrees Fahrenheit (35 to 49 degrees Celsius) and the temperature of the hot water used for patient bathing between 95 degrees and 110 degrees Fahrenheit (35 to 43 degrees Celsius).

(c) The facility shall use a sewage disposal system maintained in good repair and operated in compliance with State and local laws, ordinances, rules and regulations.

**8:42A-21.6 Laundry services**

(a) The facility shall establish and implement written policies and procedures for laundry services, including, but not limited to, policies and procedures for the following:

1. The provision of clean laundry for each patient, including blankets, when required.

2. The collection of soiled laundry so as to avoid microbial dissemination into the environment and placement in impervious bags or containers that are closed at the site and time of collection.

   i. Containers shall be in good repair, kept clean, and identified for use with either clean or soiled laundry;

3. The protection of clean laundry from contamination during processing, transporting, and storage; and

4. The sanitizing of equipment surfaces that come into contact with laundry.

(b) The facility shall provide for soiled laundry to be stored in a ventilated area separate from any other supplies.

1. Soiled laundry shall not be stored, sorted, rinsed, or laundered in patient areas, bathrooms, areas of food preparation and/or storage, or areas in which clean laundry and/or equipment are stored.

(c) If the facility has an in-house laundry, it shall have a receiving, holding, and sorting area with hand washing facilities accessible to the area. The walls, floors, and ceilings of the area shall be clean and in good repair and its ventilation shall be adequate to prevent heat and odor build-up.

1. In-house laundering shall follow policies and procedures designed to reduce the number of bacteria to a safe level during the laundering process.

2. The infection control officer shall establish a protocol for linen or clothing that is not adequately processed in a normal wash cycle, for example, clothing or linen contaminated by scabies.

## SUBCHAPTER 22. QUALITY ASSURANCE PROGRAM

### 8:42A-22.1 Quality assurance plan

(a) The residential substance abuse treatment facility shall establish and implement a written plan for a quality assurance program for patient care, review it at least annually and revise it as necessary.

1. The plan shall specify a timetable for implementation and the individual responsible for coordinating the quality assurance program, and shall provide for ongoing monitoring of staff and patient care services.

(b) The facility shall establish a multidisciplinary committee responsible for the direction of the quality assurance program.

1. The committee shall include at least representation from the medical staff, nursing staff, counseling staff and administration.

2. The committee shall establish a mechanism to include participation of all disciplines in the identification of areas for review that affect patient care throughout the facility.

### 8:42A-22.2 Quality assurance activities

(a) The facility's quality assurance program shall provide for an ongoing process for monitoring and evaluating patient care services, staffing, infection prevention and control, housekeeping, sanitation, safety, maintenance of physical plant and equipment, patient care statistics, discharge planning services, and volunteer services.

1. Evaluation of patient care throughout the facility shall be criteria-based, and trigger certain review actions when specific, quantified, predetermined levels of outcomes, or potential problems are identified.

2. The quality assurance process shall include periodic review of patient clinical records.

3. The quality assurance process shall include evaluation by patients of care and services provided by the facility.

4. If the families of patients are routinely involved in the care and services provided by the facility, the quality assurance process shall include a means for obtaining input from families of patients.

5. The quality assurance process shall include at least annual review of staff qualifications and credentials and staff orientation and education.

(b) The administrator shall follow-up on the findings of the quality assurance program to ensure that effective corrective actions have been taken, or that additional corrective actions are no longer indicated or needed.

1. In addition, the administration shall follow-up on all recommendations resulting from findings of the quality assurance program.

(c) The facility shall identify and establish indicators of quality care specific to the facility. The facility shall monitor and evaluate each of the specific indicators.

(d) The facility shall submit results of the quality assurance program to its governing authority at least annually, including deficiencies found and recommendations for corrections or improvements, except that deficiencies which jeopardize patient safety shall be reported to the governing authority immediately.

## SUBCHAPTER 23. VOLUNTEER SERVICES

### 8:42A-23.1 Provision of volunteer services

(a) The residential substance abuse treatment facility may provide volunteer services as an integral part of its services.

1. Volunteers shall not provide services in lieu of staff.

2. Volunteers shall not administer medications.

(b) The facility shall provide volunteers orientation at the time of employment and continuing in-service education regarding at least emergency plans and procedures, discharge planning, and the infection prevention and control program.

(c) The facility shall ensure that patient confidentiality is maintained in accordance with its policies and all applicable laws even when volunteers have access to patient clinical records.

(d) Volunteers shall not receive gifts or gratuities from patients.

### 8:42A-23.2 Volunteer policies and procedures

(a) If the facility provides volunteer services, it shall establish and implement written policies and procedures including, but not limited to, policies and procedures regarding the following:

1. Criteria for individuals to become participants in, and excluded from, the volunteer service, including at least the following criteria:

i. Minimum age and physical examination requirements for volunteers; and

ii. The minimum period of time during which those persons who had a prior history of substance abuse (alcohol and/or drugs, nicotine) shall be continuously substance free before being accepted as volunteers;

2. Methods for obtaining information regarding each volunteer, including, at least education, work experience, and arrests or convictions, if any;

3. Assignment of volunteers to patients, including criteria for assignment; and

4. Functions which volunteers may perform.

(b) The facility shall provide for volunteer services under the supervision of staff and in accordance with patient treatment plans.

## SUBCHAPTER 24. PHYSICAL PLANT AND FUNCTIONAL REQUIREMENTS

### 8:42A-24.1 Physical plant general compliance for new construction or alteration

(a) New buildings and alterations and additions to existing buildings for freestanding residential substance abuse treatment facilities shall conform with the New Jersey Uniform Construction Code, N.J.A.C. 5:23, incorporating specified subchapters of the model code of the Building Officials and Code Administrators International (BOCA), Inc. (4051 W. Flossmoor Road, County Club Hills, IL 60477-5795), appropriate to Use Groups I-1, as amended and supplemented, and the Guidelines for Construction and Equipment of Hospital and Medical Facilities (The American Institute of Architects Press, 1735 New York Avenue, NW, Washington, DC 20006), as amended and supplemented, incorporated herein by reference.

(b) New buildings and alterations and additions to existing buildings for residential substance abuse treatment facilities which are part of an acute care hospital shall conform with the New Jersey Uniform Construction Code, N.J.A.C. 5:23, incorporating specified subchapters of the model code of the Building Officials and Code Administrators International (BOCA), Inc. (4051 W. Flossmoor Road, County Club Hills, IL 60477-5795), appropriate to Use Group I-2, as amended and supplemented, and the Guidelines for Design and Construction of Hospital and Health Care Facilities, 1996-1997, published by The American Institute of Architects Press, 1735 New York Avenue, NW, Washington, DC 20006, 202-626-7475, as amended and supplemented, incorporated herein by reference.

### 8:42A-24.2 Physical plant general compliance for construction or alteration completed prior to November 15, 1999

Buildings constructed or altered prior to November 15, 1999 shall conform with Federal, State, and local standards in effect at the time of construction, alteration, or approval of plans for construction or alteration by the Department.

### 8:42A-24.3 Plan review fees

(a) Prior to any construction, plans shall be submitted for review and approval, in accordance with the provisions of this chapter to:

Department of Community Affairs
P.O. Box 815
Trenton, NJ 08625-0815

(b) Review fees shall be paid pursuant to N.J.A.C. 8:31-1.1.

### 8:42A-24.4 Alterations, replacements and damage to existing facilities

(a) Existing structures, when repaired, renovated, altered or reconstructed, shall conform to the requirements of N.J.A.C. 5:23-6, Rehabilitation Subcode.

(b) If an existing structure is damaged by fire or any other cause, the requirements of N.J.A.C. 5:23-6, Rehabilitation Subcode, shall apply to the restoration of such building or structure.

(c) Any work which is mandated by any housing, property or fire safety maintenance code, standard or regulation or other State or local law requiring improvements to buildings or structures, shall be made to conform only to the requirements of that code, standard, law or regulation and shall not be

required to conform to the subcodes adopted pursuant to this chapter unless the code requiring the alterations so provides.

**8:42A-24.5 Provision for the handicapped**

All facilities shall be made available and accessible to the physically handicapped pursuant to the New Jersey Uniform Construction Code, N.J.A.C. 5:23.

**8:42A-24.6 Restrictions**

Mixed use occupancy shall not be permitted in buildings classified as High Hazard (H), Factory (F) or Assembly (A-2) Use Groups, in accordance with N.J.A.C. 5:23 and P.L. 100-336, the Americans with Disabilities Act, as amended and supplemented, and the Accessibility Guidelines for Buildings and Facilities, as amended and supplemented, incorporated herein by reference. The Accessibility Guidelines are available from the Superintendent of Documents, Government Printing Office, Washington, DC, 20402.

**8:42A-24.7 Ventilation**

Ventilation shall be provided in accordance with BOCA National Building Code, Chapter 12, and BOCA National Mechanical Code, Chapter 16, as incorporated in N.J.A.C. 5:23.

**8:42A-24.8 Exit access passageway and corridors**

The width of passageways including doors, aisles and corridors in a facility shall not be less than 44 inches. If an existing building(s) is being converted to a residential substance abuse treatment facility, in whole or part, the authority having jurisdiction may consider an exception which would allow a 36 inch corridor, in accordance with N.J.A.C. 8:42A-2.6.

**8:42A-24.9 Automatic fire alarm system and detectors systems**

(a) The facility shall have smoke detectors throughout the physical plant, which shall be in accordance with all applicable sections of the rules of the Department of Community Affairs at N.J.A.C. 5:23 and 5:70, incorporated herein by reference.

(b) The facilities shall connect their alarm systems to a full-time fire station or police station or other approved agency.

(c) All detectors including those for doors, windows, shelters and smoke detectors shall be hardwired and connected to a fire alarm system.

**8:42A-24.10 Fire suppression systems**

The facility shall have an automatic fire suppression system(s) in accordance with all applicable sections of N.J.A.C. 5:23 and 5:70, incorporated herein by reference.

**8:42A-24.11 Interior finish requirement**

Interior wall and ceiling finishes shall be installed in accordance with all applicable sections of the rules of the Department of Community Affairs at N.J.A.C. 5:23 and 5:70.

**8:42A-24.12 Attached structures**

(a) Attached structures such as storage sheds or private garages located beneath the buildings shall have fire separation assemblies at the walls, floors, and ceilings separating the space from the adjacent interior enclosed space constructed of not less than one-hour fire resistance rating.

(b) Attached private garages shall be completely separated from the adjacent interior enclosed spaces and the attic area by means of one-hour fire rated separation assembly applied to the garage side.

(c) The sills of all door openings in the garage between garage and building shall be raised not less than four inches above the garage floor and openings shall be protected in accordance with the rules of the Department of Community Affairs at N.J.A.C. 5:23 and 5:70.

## SUBCHAPTER 25. PHYSICAL ENVIRONMENT

### 8:42A-25.1 Resident bedrooms and baths

(a) Residential substance abuse treatment facilities shall provide sleeping rooms for each patient, subject to the following:

1. Rooms for a single patient shall have a minimum of 70 square feet of clear floor space.

2. Rooms for multiple patients shall have a minimum of 50 square feet of clear floor space per patient, with three feet of clear floor space between and at the foot of beds.

    i. Storage space and a non-folding chairs shall be provided for each patient.

3. Rooms for mothers in treatment with one or more children shall have a minimum of 50 square feet of clear floor space per occupant.

    i. Bunk beds shall not be used by pregnant women or preschool age children.

    ii. Crib and playpen slats shall be no more than 2 3/8 inches apart.

    iii. Mattresses shall be fire retardant and all mattresses used in cribs and playpens shall fit snugly.

    iv. The top rails of cribs and playpens shall be at least 19 inches above the mattresses.

    v. Locks or latches on the dropside of cribs shall be safe from accidental release.

4. Sleeping room doors shall be lockable only from the corridor side using a key, and exit from the room shall be possible at all times by turn of a knob or a lever.

    i. Duplicate keys shall be carried by designated staff at all times.

5. There shall be a bedside light for each bed, in addition to ceiling lights or other fixtures suitable for lighting the entire room.

6. There shall be at least a duplex outlet for each bed.

(b) Facilities shall provide on each floor with patient sleeping rooms, toilets and baths accessible from a common corridor (if not otherwise adjacent to each sleeping room), as follows:

1. There shall be one water closet for every eight patients.

2. There shall be one hand-washing sink for every eight patients.

3. There shall be one shower or tub for every eight patients, but not less than one tub for every 50 patients per floor, whichever method provides the greater tub to patient ratio.

4. Facilities serving both male and female patients shall provide separate designated shower and toilet facilities in accordance with ratios designated in (b)l through 3 above.

(c) Facilities shall provide at least one water closet and hand washing sink accessible from a common corridor on all other floors.

1. If individual bathroom facilities are unavailable for male and female patients, then the single bathroom must be clearly marked to indicate usage by both.

(d) Facilities serving both male and female patients shall maintain separation of sleeping quarters.

**8:42A-25.2 Living and recreation rooms**

(a) Facilities shall have a living room or rooms of sufficient size to seat two-thirds of the licensed capacity of the facility with at least 15 square feet per patient.

(b) In addition, the facility shall have living room(s) with ample space for socialization and other patient activities, including letter writing, card playing, board games, reading, listening to radio or television.

**8:42A-25.3 Dining rooms**

(a) Facilities shall have a dining room or rooms equipped to seat at least half of its patients at one time, with 15 square feet allotted for each patient.

(b) Facilities may use the dining room(s) for patient recreation activities other than during service times, but the dining room shall not be a part of any other room in the facility.

**8:42A-25.4 Storage**

Facilities shall provide a minimum of 10 square feet of lighted storage space per patient for the storage of clothing, linens, foods, cleaning and other supplies.

**8:42A-25.5 Laundry equipment**

(a) Facilities shall provide at least one noncommercial washer and dryer for patient use.

(b) The facilities that use commercial laundry equipment shall install such equipment in a separate laundry room, with the remainder of the facility protected from the laundry room by fire separation assemblies of at least one-hour fire resistance and doors which provide protection (to the laundry room) in accordance with the rules of the New Jersey Department of Community Affairs at N.J.A.C. 5:23.

(c) Facilities shall vent all dryers to the outside of the buildings in which the dryers are located.

**8:42A-25.6 Kitchens**

The facility shall keep all kitchen exhaust fans and metal ducts free of grease and dirt, and metal ducts shall comply with the rules of the Department of Community Affairs at N.J.A.C. 5:23.

**8:42A-25.7 Fire extinguisher specifications**

(a) The facility shall keep a minimum of two fire extinguishers in the basement or in a place which will ensure that there is a fire extinguisher within 50 feet of any oil or gas used as a fuel source. There should be at least one fire extinguisher on each floor or as many as necessary to ensure that no one must travel more than 75 feet (excluding the kitchen), and as many as may be necessary in or near

the kitchen to assure that a fire extinguisher is within 50 feet of any ranges and stoves. All of the extinguishers shall bear the seal of the Underwriters Laboratory.

1. Fire extinguishers in all kitchen areas shall be Class B dry chemical type 2-B, and a minimum of five pounds.

2. Fire extinguishers in the basement shall comply with (a)l above, if oil or gas is used as a fuel source.

3. In all other instances, fire extinguishers may be Class A air-pressurized 2.5 gallon water type 2-A.

**8:42A-25.8 Employee sleeping rooms**

Facilities shall equip employee's sleeping room(s) with a four inch alarm bell that is connected to the fire alarm system.

**8:42A-25.9 Sounding devices**

(a) Facilities shall have an intercom system with an alarm on every floor, which shall ring in the employee's sleeping room(s) and at any area staffed 24 hours a day.

(b) Facilities shall equip self-locking doors at main entrances, and entrances to a roof or balcony with a sounding device affixed to the outside of the door or adjacent wall that shall ring at an area staffed 24 hours a day and the employee's sleeping room(s), when engaged.

**8:42A-25.10 Ceiling heights**

The facilities shall have ceiling heights in corridors, storage rooms, patient rooms, bathrooms and lavatories in accordance with the rules of the New Jersey Department of Community Affairs at N.J.A.C. 5:23. Ceilings in other spaces not normally occupied may be reduced to seven feet in height.

## SUBCHAPTER 26. EXISTING FACILITIES

### 8:42A-26.1 Physical plant standards for all existing licensed facilities

Existing licensed residential substance abuse treatment facilities shall comply with, and shall continue to be inspected according to, those codes and standards which were in effect at the time of their initial licensure.

### 8:42A-26.2 Fire safety

Smoke detectors, fire suppression systems, and building separations shall be in compliance with the Uniform Fire Code of the State of New Jersey, N.J.A.C. 5:70-3 and 4, as applicable.

### 8:42A-26.3 Resident bedrooms

Existing licensed facilities shall have 70 square feet of floor space for single rooms and 50 square feet of floor space per resident in multi-bed rooms.